

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

Deceased with Dr. [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12533 Item #2b & c Film #G392 9/22/67 rh											
CERTIFICATE OF DEATH											
12543											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS</u>						d. STREET ADDRESS <u>8811 ENFIELD COURT</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DEBORAH</u> Middle <u>LYNN</u> Last <u>ALBERTS</u>						4. DATE OF DEATH Month <u>SEPT</u> Day <u>14</u> Year <u>1967</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/23/66</u>		9. AGE (In years lost birthday) <u>1 yr.</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				11b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE E. ALBERTS</u>						14. MOTHER'S MAIDEN NAME <u>TERESSA MERRICK</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>#13</u>				Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 7441 DUE TO (b) <u>Muscular Dystrophy</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 13, 1967</u> , to <u>Sept 13, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 13, 1967</u> , and that death occurred at <u>---</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Albert J. Moolin MD</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-14-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ALBERT J MOOLIN MD</u>						22d. ADDRESS <u>704 Gorman Ave Laurel MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State) <u>SPOKANE WASH.</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>550 WASH BVD</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					
DATE <u>SEP 19 1967</u>											

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to your papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MONTGOMERY STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12534		CERTIFICATE OF DEATH	
12542			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>1507 Whippoorwill Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Beatrice Ann Allcock</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 December 1934</u>
9. AGE (In years last birthday) yrs. <u>32</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Andrew J. Orlosky</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Hunter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Not available</u>	
17. INFORMANT <u>The Medical Records</u>		18. ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas (Wide spread Metastases)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>		21. I certify that (X) (this hospital) attended the deceased from <u>September 20 1967</u> , to <u>September 27 1967</u> , that (X) (we) last saw the deceased alive on <u>September 27 1967</u> , and that death occurred at <u>2:00 AM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Michael Emmer</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>27 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Michael Emmer, MD.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Oct 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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1917

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

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Business communications should be sent to the Business Manager.

Reprints of articles may be obtained from the publisher.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12535

12544

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		e. STREET ADDRESS 304 69th Place	
3. NAME OF DECEASED (Type or print) First Linda Middle B. Last Amos		4. DATE OF DEATH Month September Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1886
9a. AGE (In years last birthday) 80		9b. IF UNDER 1 YEAR Months 10 Days 15 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Redding		14. MOTHER'S MAIDEN NAME Jenny Ellyson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Raymond H. Amos		Address 304 69th Place Seat Pleasant	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral vascular accident 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral vascular arteriosclerosis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 15 yrs 15 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-16-67 , to 9-20-67 , that (I) (we) last saw the deceased alive on 9-16-67 , and that death occurred at 9-20-67 M, from causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED Sept. 20, 1967	
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22d. ADDRESS 6124 Central Ave. Capital Hgts. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-22-1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR DATE SEP 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

12536				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12545			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges <i>Chas.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road		08.2					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS Route 1 Box 147		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARVEY ROBERT ARNOLD <i>Arnold</i>				4. DATE OF DEATH Month 9 Day 30 Year 1967							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1902					
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Circus Worker				10b. KIND OF BUSINESS OR INDUSTRY Marshall Hall		14. MOTHER'S MAIDEN NAME Glennie V. Coates					
13. FATHER'S NAME Robert H. Arnold				17. INFORMANT Address Maryland Evelyn V. Moore 3509 79th Ave Forestville							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguinating hemorrhage due DUE TO to hemorrhagic diathesis status DUE TO post aortagraft embolus to coronary CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 8/29 , 19 67 , to 9/30 , 19 67 , that (I) (we) last saw the deceased alive on 9/30 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.											
22a. SIGNATURE Frederick Y. Donn				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Frederick Y. DONN					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland Maryland					
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR OCT 5 1967		25b. REGISTRAR'S SIGNATURE					

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12537

CERTIFICATE OF DEATH

12548

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY MONT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs	
c. LENGTH OF STAY IN lb 1 Hour		d. STREET ADDRESS 8201 16th Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Asher BADT		4. DATE OF DEATH Month September Day 8th Year 1967	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 SEP 1884
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) TYLER TEXAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph BADT		14. MOTHER'S MAIDEN NAME Ida SPIRO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578-40-9963	
17. INFORMANT Jennie (NMN) BADT		Address Silver Springs, 16th St. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Acute Myocardial Infarction 4201 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Coronary Arteriosclerosis DUE TO (c) Coroner notified at 2115 8 Sept 1967			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 8 SEP 1967 to 8 SEP 1967 , that (X) (we) last saw the deceased alive on 8 SEP 1967 , and that death occurred at 7:21P M, from causes and on the date stated above.			
22a. SIGNATURE E. VAN HOVE for LEDR MC		22b. DATE SIGNED 9 Sept 1967	
22c. PHYSICIAN'S NAME (Type) M.D.R. FOREMAN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE THEREOF 12 SEP 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington, National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL HOME Goldberg Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 13 1967	
ADDRESS 4217 9th St. N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

125338

12547

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C. 20018</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frances BAHN Bailey</u>		4. DATE OF DEATH Month Day Year <u>September 10 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1889</u>
9. AGE (In years last birthday) <u>78 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (County & State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Eugene Bahn</u>		14. MOTHER'S MAIDEN NAME <u>HAVANA HARBOLD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>WA 507757</u>	
17. INFORMANT Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>coronary heart failure</u> DUE TO <u>fulminant coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cerebral vascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>67</u> , to <u>9/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> , 19 <u>67</u> , and that death occurred at <u>1:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>		22d. ADDRESS <u>7852 16th Ave NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Sept 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Harold L. Leach, Paul M. [Signature]</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

■ A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12539

CERTIFICATE OF DEATH

12549

1 PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 12 Macgill Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mackey Lee Baliles		4. DATE OF DEATH Month September Day 15 Year 1967	
5 SEX Male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-97
9 AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10	11. IF UNDER 24 HRS Hours 10 Min 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. Transit-retired		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Barney Baliles		14. MOTHER'S MAIDEN NAME Lucinda Foley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-10-5979h	
17. INFORMANT Patinet's chaft		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 26 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/13 , 19 67 , to 9/15 , 19 67 , that (I) (we) lost saw the deceased alive on 9/15/67 , 19 67 , and that death occurred at 3:42 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Alan R. Gair		22b. DATE SIGNED 9/15/67	
22c. PHYSICIAN'S NAME (Type) Alan R. Gair M.D.		22d. ADDRESS 7777 Maple Ave, Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Md	
24. FUNERAL DIRECTOR Arthur Miller		25a. RECEIVED BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge		25c. ADDRESS 254 Carroll St N.W. Wash. D.C.	

CERTIFICATE OF DEATH

125-0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6821 Wilson Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Paul F. Barber</u>		4. DATE OF DEATH <u>Sept. 20</u> 19 <u>67</u>	
5. SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1919</u>
9 AGE (In years lost birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Asst. Co. Elevator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Barber, John E.</u>		14. MOTHER'S MAIDEN NAME <u>Poore, Martha Anna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>577-12-4880</u>	
17 INFORMANT <u>Wife Helen Kildell Barber</u>		Address <u>Western #2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction due to Coronary</u> DUE TO <u>Arteriosclerosis with Thrombosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 1967</u> to <u>Sept 20 1967</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>George Sharpe</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George Sharpe, M.D.</u>		22d. ADDRESS <u>10400 Conn. Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-25-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery/ Silver Spring, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12541

12550

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>South Carolina</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>28 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Florence</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>552 Santiago Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Leroy Hugh Barefoot, Jr.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>19</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>13 April 1966</u>		9. AGE (In years lost birthday) <u>1</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leroy H. Barefoot, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Harvey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> <u>1570</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>17 Mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, off ice bldg, etc)	20f. (City or town) (County) (State)				
21. I certify that (X) (this hospital) attended the deceased from <u>22 August</u> , 19 <u>67</u> , to <u>19 Sept.</u> , 1967, that (X) (we) lost the deceased alive on <u>19 Sept.</u> , 1967, and that death occurred at <u>12:07 M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Lynn M. Peterson</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lynn M. Peterson, M. D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 9-20-67</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Florence, So. Carolina</u>		25b. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 25 1967</u>		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

12542

CERTIFICATE OF DEATH

12551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN It <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>15105 Hildegard Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank James Barr</u>				4. DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6-23-83</u>		9. AGE (In years lost birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US GOVERNMENT</u>		11. BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DANIEL Samuel Barr</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH Gunther</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-50-8352</u>		17. INFORMANT <u>Hospital Record</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Pulmonary Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>metastatic Ca - undetermined primary</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March, 1965</u> to <u>Sept 1, 1967</u> , that (I) (we) lost the deceased alive on <u>Sept 1, 1967</u> , and that death occurred at <u> </u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>				22d. ADDRESS <u>Burtonsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Laurel Grove Pike, Ohio</u>	
24. FUNERAL DIRECTOR <u>Dr. Witt Donaldson Laurel, Md.</u>				25a. RECD BY REGISTRAR <u>SEP 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12543

12552

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Georgia</u> b. COUNTY <u>Fulton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>At home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Palomar Valley Nursing Home</u>		d. STREET ADDRESS <u>1329 Virginia Ave NE</u>	
3. NAME OF DECEASED (Type or print) <u>Memphis S. Borlitt</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jun. 15 1892</u>
9. AGE (in years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Macon Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leslie Holloway</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>417484582</u>	
17. INFORMANT <u>Mrs. Rosal Kopp</u>		Address <u>619 Wopel Dr Rockville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO (b) <u>Metastatic Carcinoma</u> DUE TO (c) <u>Primary Carcinoma of the Lung</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>1 year</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1967, to <u>Sept 11</u> , 1967, that (I) (we) last saw the deceased alive on <u>Sept 7</u> , 1967, and that death occurred at <u>2P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William H Killian</u>		22b. DATE SIGNED <u>Sept 11 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William H Killian</u>		22d. ADDRESS <u>8118 Waco Ave Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEM. ATLANTA</u>	23d. LOCATION (City or Town) (County) (State) <u>GEORGIA</u>
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>		DATE <u>SEP 14 1967</u>	

12553

CERTIFICATE OF DEATH

12544

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb Rockville		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13516 Glen Mill Road				d. STREET ADDRESS 13516 Glen Mill Road	
3. NAME OF DECEASED (Type or print) William W. Bartlow		4. DATE OF DEATH Month Sept. Day 13, Year 19 67		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1880	9. AGE (in years last birthday) 86 yrs	10. IF UNDER 1 YEAR Months 86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Bartlow		14. MOTHER'S MAIDEN NAME Mary Bardl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 186-01-5516		17. INFORMANT Mrs Russell Sweeney-Item # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Many yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes; cerebral arteriosclerosis; old fractured hip, pulm. fibrosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct. 11 , 19 65 , to Sept. 13 , 19 67 , that (I) (we) last saw the deceased alive on July 20 , 19 67 , and that death occurred at 9 A.M. from causes on and on the date stated above.			
22a. SIGNATURE <i>Sydney J. Cohen</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Sept. 13, 1967	
22c. PHYSICIAN'S NAME (Type) Sydney J. Cohen		22d. ADDRESS 50 W. Edmondston Drive, Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/67		23c. NAME OF CEMETERY OR CREMATORY Rose Lawn	
23d. LOCATION (City or Town) (County) (State) Berwick, Pennsylvania		24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Maryland			
25a. REC'D BY REGISTRAR SEP 15 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15M
6M 1/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12545

12551

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY N 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital			d. STREET ADDRESS 4314 Kaywood Dr. #101		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) Philip Henry Bath			4 DATE OF DEATH Month September Day 7 Year 1967		
5 SEX Male	6 COLOR OF RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/00	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	11. BIRTHPLACE (State or foreign country) Pittston, Penna.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Bath			14. MOTHER'S MAIDEN NAME unknown (died at birth)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO 577 07 80 32	17. INFORMANT Daughter, Address R vl., Md		
18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY: 4222 IMMEDIATE CAUSE (a) Cerebral myocardial infarction DUE TO (b) Chronic myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a.m. pm 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John S. Rogers, M.D.		CHIEF MED. CAL. EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9-7-67	
EXAMINER'S NAME (Type) John S. Rogers, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Suitland Pro Georges Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE SEP 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge	

12546

CERTIFICATE OF DEATH

12555

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Tazewell</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN lb <u>47 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>		e STREET ADDRESS <u>Box 113</u>	
3. NAME OF DECEASED (Type or print) First <u>Gussie</u> Middle <u>Lenora</u> Last <u>Beavers</u>		4 DATE OF DEATH Month <u>September</u> Day <u>5</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>22 December 1919</u>
9. AGE (In years last birthday) <u>47 yrs</u>		10 IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>1</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Education</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Pruett</u>		14. MOTHER'S MAIDEN NAME <u>Sophonra Christian</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>228-46-1984</u>	
17 INFORMANT <u>The Medical Record</u>		18 ADDRESS <u>The Clinical Center, Bethesda, Maryland</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral</u>			
DUE TO (b) <u>Hodgkin's Disease</u>			
DUE TO (c) <u>5 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>20 July</u> , 19 <u>67</u> , to <u>5 Sept.</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>5 September 1967</u> , and that death occurred at <u>4:25 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Bruce A. Chabner</u>		22b DATE SIGNED <u>Sept. 5, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bruce A. Chabner, M.D.</u>		22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>9/7/1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Green Hill Memo. Gardens</u>		23d LOCATION (City or Town) (County) (State) <u>Clay Pool Virginia</u>	
24. FUNERAL DIRECTOR <u>Ives Funeral Home, Inc.</u>		25a REC'D BY REGISTRAR <u>SEP 7 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

closed with double examiner

VR A15 (4)
25M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12547

12556

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>9005 - Kirkdale St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>							
3 NAME OF DECEASED (Type or print) <u>Richard W. Beers</u>				4 DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1967</u>			
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18 1911</u>	9 AGE (In years last birthday) <u>56</u> yrs	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland, U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hanna Nelson Beers</u>				14. MOTHER'S MAIDEN NAME <u>Stella Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WWII - 1942-1945</u>		16. SOCIAL SECURITY NO <u>577-07-1094</u>		17 INFORMANT Name <u>Helen M. Beers</u> Address <u>As above</u>			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>6 yrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg. etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Dec 9/1</u> , 19 <u>66</u> to <u>9/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/30</u> , 19 <u>67</u> , and that death occurred at <u>4:05</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>H. F. Kreuzburg</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. Kreuzburg</u>				22d. ADDRESS <u>7852 16th Ave NW, Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-5-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>SUITLAND MARYLAND</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAWLER'S SONS, INC. WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12548

12557

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>14 YEARS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>8717 Bradford Road</u>		d. STREET ADDRESS <u>8717 BRADFORD ROAD</u>	
3 NAME OF DECEASED (Type or print) <u>ROBERT W. BENNETT</u>		4 DATE OF DEATH Month <u>9</u> - Day <u>30</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 25, 1901</u>
9 AGE (in years last birthday) yrs <u>65</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>	
10b KIND OF BUSINESS OR INDUSTRY <u>Hotel - SheratonPk.</u>		11 BIRTHPLACE (State or foreign country) <u>England</u>	
12 CITIZEN OF COUNTRY <u>Great Britain</u>		13 FATHER'S NAME <u>Peter Bennett</u>	
14 MOTHER'S MAIDEN NAME <u>Unknown</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>466-46-2261</u>		17 INFORMANT Name <u>Barbara U. Bennett</u> Address <u>8717 Bradford Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <u>420.1</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Artery Heart Disease</u> (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Silver Spring, Md.</u> INTERVAL BETWEEN ONSET AND DEATH			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		22. DATE SIGNED <u>OCT. 1, 1967</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <u>Charles J. Warner</u> (County) <u>Prince Georges Co., Maryland</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Oct. 3, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Maryland</u>
24a FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a REC'D BY REGISTRAR <u>OCT 5 1967</u>	
24b FUNERAL HOME <u>Warner & Humphrey, Inc.</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. Warner</u>	
24c ADDRESS <u>8474 Georgia Ave. Silver Spring, Md.</u>			

CERTIFICATE OF DEATH

12549

12558

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>21 HRS.</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		d STREET ADDRESS <u>5907 - Wilmette Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> <u>W.</u> <u>Bantz</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/18/11</u>
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR Months <u>5</u> Days <u>2</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Contractors</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Kansas</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Bantz</u>		14 MOTHER'S MAIDEN NAME <u>Wilhelmina Lindaloff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>511-07-2119</u>	
17 INFORMANT <u>Lucille Bantz</u>		Address <u>5200</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage, massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to esophageal varices, ruptured</u> DUE TO (c) <u>due to cirrhosis, liver</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1967</u> to <u>Sept 7, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 7, 1967</u> and that death occurred at <u>5:30</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Robert G. Brewer</u>		22b DATE SIGNED <u>9/7/67</u>	
22c PHYSICIAN'S NAME (Type) <u>ROBERT G. BREWER</u>		22d ADDRESS <u>8505 Old Georgetown Road Bethesda, Maryland</u>	
23a BURIAL, CREMATON, REMOVAL (Specify)	23b DATE THEREOF <u>9-11-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. HUMPHREY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>SEP 14 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12550

CERTIFICATE OF DEATH

12559

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b 15-1		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanatorium		d. STREET ADDRESS 8500 - 16th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACK Middle MYER Last BISCARR		4. DATE OF DEATH Month Sept. Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 August 1902 9. AGE (In years last birthday) 65 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) Mgr. Retail Store		10b. KIND OF BUSINESS OR INDUSTRY Shoe	
11. BIRTHPLACE (County & State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip Bisgyer		14. MOTHER'S MAIDEN NAME Violet Rosenblatt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-4808A	
17. INFORMANT Donald Biscarr		Address 4118 Havard St., SSpg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Aneurysm 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Art. Heart Disease DUE TO (c) 0 yro			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 15 1967 , 19 65 to Sept 15 1967 , that (I) (we) last saw the deceased alive on Sept 15 1967 , and that death occurred at 4 P.M. from causes and on the date stated above.			
22a. SIGNATURE Isidore Shulman M.D.		22b. DATE SIGNED 9-27-67	
22c. PHYSICIAN'S NAME (Type) Isidore Shulman, M.D.		22d. ADDRESS 915 19th Street N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-28-67	23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park	23d. LOCATION (City or Town) (County) (State) Falls Church, Va.
24. FUNERAL DIRECTOR Goldberg Funeral Home		25a. REC'D BY REGISTRAR SEP 28 1967	
ADDRESS 4217 9th Street N.W.		25b. REGISTRAR'S SIGNATURE Charles Judge	

12551

CERTIFICATE OF DEATH

12560

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 150 days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Georgia		b. COUNTY Blakely	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland						e. STREET ADDRESS Route 1, Box 3			
3 NAME OF DECEASED (Type or print) First Middle Last John Henry Blakely						4. DATE OF DEATH Month Day Year September 21 19 67			
5. SEX Male		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 28 May 1960		9. AGE (In years last birthday) 7 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child (None)				10b. KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State, or foreign country) Georgia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Carl Blakely						14. MOTHER'S MAIDEN NAME Carol Erenheim			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO None		17 INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland 20014			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from April 24, 19 67, to Sept. 21, 1967, that (he) (we) last saw the deceased alive on Sept. 21, 19 67, and that death occurred at 10:10 AM, from causes and on the date stated above.									
22a SIGNATURE F. Carl Grumet						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b DATE SIGNED 21 Sept. 1967	
22c PHYSICIAN'S NAME (Type) F. Carl Grumet, MD						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 9-22-67		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State) None here			
24 FUNERAL DIRECTOR 3570 F.W. NEWELL						25a REC'D BY REGISTRAR DATE SEP 26 1967		25b REGISTRAR'S SIGNATURE James J. [Signature]	

12552

CERTIFICATE OF DEATH

12561

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where dec lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>1000 Narahoe Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Blendman Sarah Ann Blendman</u>		4. DATE OF DEATH Month Day Year <u>9 7 1967</u>	
5. SEX <u>Female</u>	6. CO. OR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1917</u>
9. AGE (In years last birthday) <u>87 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>87 yrs</u>	
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>220-48-6198</u>	
17. INFORMANT <u>Mrs. Harold Fainberg</u>		Address <u>S.S. Md. 1000 Narahoe Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarction with atherosclerosis of the heart</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>6/19</u> , 19 <u>67</u> and that death occurred at <u>2:22</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Benjamin Manchester</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN MANCHESTER</u>		22d. ADDRESS <u>3200-16 St N St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Adas Israel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Donald M. Stein Hebrew Memorial Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12553

12562

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>47 Days</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d STREET ADDRESS <u>45 South Paula Street</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Edward Bly</u>				4. DATE OF DEATH Month Day Year <u>September 2, 19 67</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 February 1953</u>		9. AGE (In years lost birthday) <u>14</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b KIND OF BUSINESS OR INDUSTRY <u>--</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Curtis A. Bly</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Souder</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No --</u>		16. SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>The Medical Records</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pleural Effusion</u> DUE TO (c) <u>Hodgkin's Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>1 month</u> <u>1 year</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia; Herpes Zoster</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21. I certify that (M) (this hospital) attended the deceased from <u>17 July</u> , 19 <u>67</u> to <u>2 Sept.</u> , 1967, that (M) (we) last saw the deceased alive on <u>2 Sept.</u> , 19 <u>67</u> , and that death occurred at <u>8:55 M.</u> , from causes and on the date stated above							
22a SIGNATURE <u>Robert C. Young</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b DATE SIGNED <u>2 September 1967</u>		
22c PHYSICIAN'S NAME (Type) <u>Robert C. Young, M.D.</u>				22d ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 6, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d LOCATION (City or town) (County) (State) <u>Suitland Md.</u>			
24 FUNERAL DIRECTOR <u>John B. Thomas</u>				25a REC'D BY REGISTRAR <u>SEP 8 1967</u>		25b REG STRAR'S SIGNATURE <u>Charles Judge</u>	
26 ADDRESS <u>Carner E. Pumphrey, Inc. 8434 Ga. Ave. S.E., Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #7 Film #G348 9/25/67 ph											
12554											
12563											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Wayne</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN IB <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waymart</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>						d. STREET ADDRESS <u>Box 16</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>Emory</u> Last <u>Bond</u>						4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 12, 1908</u>		9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard: Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Myron Bond</u>						14. MOTHER'S MAIDEN NAME <u>Edith Emory</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>211-12-1035</u>		17. INFORMANT <u>The Medical Records</u> Address <u>20014 The Clinical Center, Bethesda, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Bone Marrow Aplasia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) <u>Macroglobulinemic Lymphoma</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>10 days</u> <u>4 years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20</u>		20f. (City or town) (County) (State)			
21. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>September 12 1967</u> , to <u>September 1967</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>September 20 1967</u> , and that death occurred at <u>2:30 M.</u> from causes and on the date stated above											
22a. SIGNATURE <u>Donald N. Buell MD</u>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>20 Sept. 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Donald N. Buell, M. D.</u>						22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept. 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Laanan Cem.</u>				23d. LOCATION (City or Town) (County) (State) <u>Laanan Township, Pa.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Ramsey</u>						ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d. STREET ADDRESS <u>901 Wade Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Solomon Victor</u> First <u>Booner</u> Middle <u>Booner</u> Last						4. DATE OF DEATH <u>Sept 19 1967</u> Month <u>Sept</u> Day <u>19</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 24 - 1888</u>		9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR: Months <u>1</u> Days <u>19</u> Hours <u>19</u> Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Seymour</u>						14. MOTHER'S MAIDEN NAME <u>Makala</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Daughter</u> <u>Kate Sommers</u> Address <u>Bethesda, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>5401</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Dehydration & gangrene both legs</u> DUE TO (c) <u>Arteriosclerosis & thrombosis of arteries causing post-operative gangrene</u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 days</u> <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. COND. I OR GIVEN IN PART I (a) <u>Chronic heart disease & fibrillation. History of strokes</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)							
20c. TIME OF INJURY: Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/9</u> , 19 <u>67</u> , to <u>9/19</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/19</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M, from causes and on the date stated above											
22a. SIGNATURE <u>J. R. Thistlethwaite</u>						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. R. Thistlethwaite</u>						22d. ADDRESS <u>1746 K St. N. W. Wash, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>9/21/67</u>		<u>Buena</u>		<u>Green, W. Va.</u>					
24. FUNERAL DIRECTOR <u>Lyons Keeler F. H. Rockwell, Inc.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>David J. ...</u>			
						DATE <u>SEP 22 1967</u>					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12556

12565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tab-bar papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>13 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e STREET ADDRESS <u>4610 Chestnut St</u>	
3 NAME OF DECEASED (Type or print) First <u>ADOLPH</u> Middle <u>Harry</u> Last <u>Borjes</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 29, 1883</u>
9 AGE (in years next birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Ohio</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernard Borjes</u>		14. MOTHER'S MAIDEN NAME <u>Christine Elsenheimer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Mrs. Tebbetts C. Borjes, Wife, Same as</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized arteriosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>16 Sept 1967</u> to <u>30 Sept 1967</u> that (I) (we) last saw the deceased alive on <u>27 Sept 1967</u> and that death occurred <u>9/29/67</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Herbert Martyn</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>30 Sept 67</u>	
22c PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>		22d ADDRESS <u>4740 Chevy Chase Dr.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>10/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Md</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons,</u>		25a. REC'D BY REGISTRAR <u>1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12557

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12566

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>16 YRS.</u>		d. STREET ADDRESS <u>710 SILVER SPRING AVENUE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>710 SILVER SPRING, MD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>HALE</u> Last <u>BOWMAN</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19, 1884</u>
9. AGE (In years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg. Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL BANKS BOWMAN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH DICKENS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217 091364 A</u>	
17. INFORMANT <u>MRS. TRUDA BARNES</u>		Address <u>AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF URINARY BLADDER</u> <u>10111</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>WITH LOCAL METASTASIS</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (11) (this hospital) attended the deceased from <u>7/30</u> <u>1959</u> to <u>SEPT. 2</u> , 1967, that (11) (we) last saw the deceased alive on <u>SEPT. 2</u> 1967, and that death occurred at <u>845</u> AM, from the causes and on the date stated above			
22a. SIGNATURE <u>James A. Roberts</u> M.D.		22b. DATE SIGNED <u>SEPT. 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		22d. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 6, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

12555

CERTIFICATE OF DEATH

12567

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE North Carolina b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY in lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS MOQ 2102 MCB	
3 NAME OF DECEASED (Type or print) First William Middle Terrill Last BRAY		4. DATE OF DEATH Month September Day 28 Year 19 67	
5 SEX Male	6. COLOR OR RACE Cauc	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Dec. 14, 1916
9 AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Oak Park, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William John Bray		14. MOTHER'S MAIDEN NAME Louise Terrill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1941-1967		16. SOCIAL SECURITY NO. 348 01 0974	
17. INFORMANT Camp LeJuene, North Carolina		Mrs. Harriet Bray, MOQ 2102, MCB	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lymphatic Chronic Lymphatic/Leukemia with bilateral bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 21, 1967 , to Sept. 28, 1967 , that (I) (we) last saw the deceased alive on Sept. 28, 1967 , and that death occurred at 655 P.M. from causes and on the date stated above			
22a. SIGNATURE <i>David R. Foreman</i>		22b. DATE SIGNED Sept. 29, 1967	
22c. PHYSICIAN'S NAME (Type) David R. Foreman, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/3/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Falls Church Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
1102 West Broad Street, Falls Church, Va.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12568

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 7 hours		d. STREET ADDRESS 9020 Fairfield Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last HANNAH MARY BROOME		4 DATE OF DEATH Month Day Year Sept. 11, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 5, 1886
9 AGE (In years last birthday) 81 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Camden, Ohio		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Dr. Charles C. Jones		14 MOTHER'S MAIDEN NAME Lillie Moreatt	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 220-44-1448	
17 INFORMANT Daughter		Address Eleanor Broome	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Clinical carcinoma of left breast with generalized metastases. DUE TO (b) heart with generalized metastases. DUE TO (c) metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from March 1964 to 9/11, 1967 , that (I) (we) last saw the deceased alive on 9/11, 1967 , and that death occurred at 6:50 p.m. from causes and on the date stated above			
22a SIGNATURE Arthur F. Woodward		22b DATE SIGNED 9/12/67	
22c PHYSICIAN'S NAME (Type) ARTHUR F. WOODWARD		22d ADDRESS 115 N. VanBuren Street Rockville, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 9-13-67	
23c NAME OF CEMETERY OR CREMATORY Darnestown Presby. Cem.		23d LOCATION (City or Town) (County) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR SEP 14 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12569

12560

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		c LENGTH OF STAY IN 1b years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11301 Rokeby Ave.		e STREET ADDRESS 11301 Rokeby Ave.	
3 NAME OF DECEASED (Type or print) GEORGE THOMAS BROWN		4 DATE OF DEATH Month Sept. Day 21 Year 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1907
9. AGE (In years lost birthday) 60 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist		10b KIND OF BUSINESS OR INDUSTRY U. S. Govt	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Albert Brown		14. MOTHER'S MAIDEN NAME Rosina Franz	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 215-26-0659	
17. INFORMANT Ann B. Brown		Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Anterior to Heart Failure DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-26 , 19 63 , to Sept 21 , 19 67 , that (I) (we) last saw the deceased alive on Sept 20 , 19 67 , and that death occurred on Sept 21 , 19 67 , from causes and on the date stated above.			
22a SIGNATURE George Sharpe		22b. DATE SIGNED 9-21-67	
22c PHYSICIAN'S NAME (Type) GEORGE SHARPE		22d ADDRESS 10400 Conn. Av. Kensington, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-23-67	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24 FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a REC'D BY REGISTRAR DATE SEP 25 1967	
		25b REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
12561											
12570											
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 4434 Hallet Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) STACEY First SUE Middle BURBANK Last						4 DATE OF DEATH Month September Day 13 Year 19 67					
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-37		9. AGE (In years last birthday) yrs 11 Months 5		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Perry F. Burbank III						14. MOTHER'S MAIDEN NAME Susan Robert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Perry F. Burbank III				Address Father- same item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 141.2 Congestive heart failure 1 month DUE TO (b) Pulmonary insufficiency 1 month DUE TO (c) malignant teratoma 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) ---							
20c. TIME OF INJURY Month, Day, Year Hour o m pm 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JUNE , 1967, to Sept 12 , 1967, that (I) (we) last saw the deceased alive on Sept. 12 1967, and that death occurred at 9:30 P M, from causes and on the date stated above											
22a. SIGNATURE Edward J Feroli						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/14/67			
22c. PHYSICIAN'S NAME (Type) Edward Feroli						22d. ADDRESS 213 N. Frederick Ave., Gaithersburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/67		23c. NAME OF CEMETERY OR CREMATORY Parklawn				23d. LOCATION (City or town) (County) (State) Rockville, Maryland			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home						ADDRESS 1331 Rock Pike		25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE William Judge	
						DATE SEP 18 1967					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared for release by Dr. Reap, Medical Examiner

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
12562						12571							
CERTIFICATE OF DEATH													
1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery Gen. Hospital						d. STREET ADDRESS 27129 Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Paul			First Middle Last Paul NMN Burner			4. DATE OF DEATH September 22 19 67			Month Day Year				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/2/97		9. AGE (In years lost birthday) 69 yrs		IF UNDER 1 YEAR Months Days Hours Min.			
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Mont. Cty. Roads		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Arthur B. Burner						14. MOTHER'S MAIDEN NAME Otta Smoot							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 579.286537		17. INFORMANT Medical Records - Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) stoking the underlying cause last. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH 1 day 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) was attended the deceased from 10/18 , 19 65 , to 9/22 , 19 67 , that (I) was attended the deceased alive on 9/22 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.													
22a. SIGNATURE James P. Kerr						M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED 9/23/67				
22c. PHYSICIAN'S NAME (Type) James P. Kerr, M.D.						22d. ADDRESS Ridge Road, Damascus, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9-25-67		23c. NAME OF CEMETERY OR CREMATORY Damascus			23d. LOCATION (City or town) (County) (State) Damascus Mont. Md.					
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.						25a. REC'D BY REGISTRAR DATE SEP 26 1967			25b. REGISTRAR'S SIGNATURE [Signature]				



CERTIFICATE OF DEATH

Reg. Dist. No.

12563

12572

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY XXXX <i>Prince George</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>				c. LENGTH OF STAY IN TB <i>4 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Althea Woodland Nursing Home 1000 Daleview Dr.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Nellie</i> Middle <i>Ethel</i> Last <i>Burton</i>				4. DATE OF DEATH Month <i>September</i> Day <i>1</i> Year <i>19 67</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 17, 1884</i>	
9. AGE (In years lost birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months <i>3</i> Days <i>1</i> Hours <i>19</i> Min.		IF UNDER 24 HRS. Hours <i>19</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Owner</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Florist & Nurseries</i>			
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>William T. Gessford</i>				14. MOTHER'S MAIDEN NAME <i>Ida Shepperson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-32-8226 A</i>			
17. INFORMANT <i>William G. Burton</i>				Address <i>7002 Lovell Dr. Hyattsville</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>1200 Congestive heart failure</i> DUE TO (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Generalized arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>10 years</i> <i>10 years</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1950</i> , 19 to <i>9-1-67</i> , that I last saw the deceased alive on <i>9-1-67</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James T. Burns</i> M.D.				ADDRESS (Street, city or town, state) <i>1835 1st Ave. Wash. D.C. 20006</i>			
DATE SIGNED <i>9-1-67</i>							
PHYSICIAN'S NAME (Type) <i>JAMES T. BURNS M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>Sept. 5, 1967</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>				22d. LOCATION (City, town, or county) (State) <i>P.G. co. Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. Glen Carter</i>				24a. REC'D BY REGISTRAR <i>SEP 8 1967</i>			
24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12564

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>36 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4401 East West Hwy Apt 402</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cecil</u>		4. DATE OF DEATH Month <u>Sept</u> - <u>23</u> 19 <u>67</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/6/1892</u>	
9. AGE (In years lost birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Acct. Off. Manager</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>South Africa</u>		14. CITIZEN OF WHAT COUNTRY? <u>South Africa</u>	
15. FATHER'S NAME <u>John Bernard Callanan</u>		16. MOTHER'S MAIDEN NAME <u>Pauline Sangis</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war, date, & grade) <u>No</u>		18. SOCIAL SECURITY NO <u>None</u>	
19. INFORMANT <u>John P. Callanan</u>		20. ADDRESS <u>Same as Item 2.</u>	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Malignant Melanoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		22. INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>	
23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		25b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of items 18)	
26a. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		26b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
26c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26d. (City or town) (County) (State)	
27. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>67</u> to <u>9/22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/22</u> , 19 <u>67</u> and that death occurred at <u>9/23</u> , 19 <u>67</u> from causes and on the date stated above		28. DATE SIGNED <u>9/23/67</u>	
29a. SIGNATURE <u>A.J. Brennan</u>		29b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN	
29c. PHYSICIAN'S NAME (Type) <u>A.J. Brennan</u>		29d. ADDRESS <u>4429 Bradley Lane Bethesda, Maryland</u>	
30a. BURIAL, CREMATION, REMOVAL (Specify)		30b. DATE THEREOF	
30c. NAME OF CEMETERY OR CREMATORY		30d. LOCATION (City or Town) (County) (State)	
30e. FUNERAL DIRECTOR		30f. ADDRESS	
30g. RECEIVED BY REGISTRAR		30h. REGISTRAR'S SIGNATURE	
30i. DATE		30j. DATE	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12574

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlesburg</u>	
c. LENGTH OF STAY IN 1b <u>1 day 2 hrs.</u>		d. STREET ADDRESS <u>Route # 1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Francis E. Calloway</u>		4. DATE OF DEATH <u>Sept. 22 1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/67</u>
9. AGE (in years last birthday) <u>60</u> yrs		FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Hedgcock</u>		14. MOTHER'S MAIDEN NAME <u>Maude Strong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-40-2866</u>	
17. INFORMANT <u>Edward Calloway</u>		Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Brecho Pneumonia</u> DUE TO (b) <u>Adeno Carcinoma of Colon with metastasis</u> DUE TO (c) <u>3 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>9/22/67</u>	
EXAMINER'S NAME (Type) <u>Dr. John G. Ball</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Montgomery Co., Md.</u>	
23a. BURIAL, CREMATION, REMOVA (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Frederick, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert E. Dailey & Son</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>	
ADDRESS <u>Frederick, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2d Film #G382 2/23/67 ph

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN IS 12/13/51 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 218 Shaw Ave 12/13/51 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Emma A. Campbell First Middle Last 4 DATE OF DEATH Sept. 10, 1967 Month Day Year		5 SEX F 6 COLOR OR RACE White 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH Sept. 13, 1888 9. AGE (in years lost in day) yrs 78	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b KIND OF BUSINESS OR INDUSTRY at home		11 BIRTHPLACE (County & State, or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel T. Addison		14. MOTHER'S MAIDEN NAME Mary Elizabeth Micou	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT Mr. Addison Campbell Address 174 Vellard Ave N. Y. Hastings			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. 410X IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO (b) Cong Heart Failure DUE TO (c) Mitral Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2-3 years 50 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED <input checked="" type="checkbox"/> White <input type="checkbox"/> Not White at work <input type="checkbox"/> of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-2 , 1966, to 9-10 , 1967, that (I) (we) last saw the deceased alive on 9-9 , 1967, and that death occurred at 6:50 AM , from causes and on the date stated above			
22a SIGNATURE R. H. Sandstrom		22b. DATE SIGNED 9-10-67	
22c PHYSICIAN'S NAME (Type) R. H. Sandstrom		22d ADDRESS 7701 Carroll Ave Takoma Park, Md	
23a BURIAL CREMATION, REMOVAL (Specify) Cremation		23b DATE THEREOF 9/11/67	
23c NAME OF CEMETERY OR CREMATORY Loudon Park		23d LOCATION (City or town) (County) (State) Baltimore, Md.	
24 FUNERAL DIRECTOR William J. Zickner & Sons North & P. Ave		25a REC'D BY REGISTRAR DATE SEP 15 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

12566

12575

CERTIFICATE OF DEATH

12576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>50 days</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Hellam</u> <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>R.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Christine Marie Carbaugh</u>				4. DATE OF DEATH Month Day Year <u>September 28 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>14 May 1961</u>	9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Carbaugh</u>				14. MOTHER'S MAIDEN NAME <u>JoAnn Van Valkenburgh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 204-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Multiple Microabscesses</u> DUE TO (c) <u>Acute Lymphocytic Leukemia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>2 weeks</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>9 August, 1967</u> , to <u>28 Sept., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>28 Sept., 1967</u> , and that death occurred at <u>9:55 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Young</u>				M.O. ATTENDING PHYS <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>29 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Young, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-2-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Columbia, Penna.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12568

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>2 wks</u>		d. STREET ADDRESS <u>1110 Fiddler Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1110 FIDDLER LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wayman D Carmichael</u>		4. DATE OF DEATH <u>Sept. 9</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 10, 1920</u>
9. AGE (In years last birthday) <u>46</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Management</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Carmichael</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Wayman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mrs. Janet M. Carmichael</u>		Address <u>1110 Fiddler Lane Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Chronic myocardial infarction</u> DUE TO (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, playground, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John L. Rogers</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John L. Rogers, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>9-9-57</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Abbey of the Chimes</u>		23d. LOCATION (City or Town) (County) (State) <u>Vallejo, California</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

12563

CERTIFICATE OF DEATH

12578

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Chase</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>8804 Walnut Hill Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Louise W. Chase</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1894</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh H. Weedon</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Linscombe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>377-01-33250</u>	
17. INFORMANT <u>Brother - Sidney Weedon</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive pulmonary disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> , 19 <u>67</u> to <u>present</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept. 20, 1967</u> , and that death occurred at <u>10:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Umhau</u> M.D.		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John B. Umhau</u>		22d. ADDRESS <u>8805 Conq. Ave. Ch. G. Md</u>	
23a. BURIAL, CREMATION, REMOVAL <u>by</u>	23b. DATE THEREOF <u>9-26-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Sutland Md Prince Geo</u>
24. FUNERAL DIRECTOR, <u>Robert A Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave Bethesda Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Maryland		b. COUNTY		Montg,
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Gaithersburg				3 yrs		Gaithersburg						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						7 Chestnut Street						
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH Month Day Year		
Eugenia				Athelia		Childers		Sept		4th		1967
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		White		<input checked="" type="checkbox"/> NEVER MARRIED		Nov 30th 1902		64 yrs.		Months Days		Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY
House Wife				11				Elkins, W. Va				U S A
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
Eugene D. Liller						Lillian E. Simms						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
				218-20-2430		Kathleen E. Hanna		Gaithersburg, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												2 days
DUE TO												3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO												
(c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED?
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)
19												
21. I certify that (I) (this hospital) attended the deceased from 1/30 to 9/4, 1967, that (I) (we) last saw the deceased alive on 9/7, 1967, and that death occurred at 3:55 A.M. from the causes and on the date stated above												22b. DATE SIGNED
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS						
Melvin J. Kordon MD						13 Deer Park Drive Gaithersburg Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
Burial				9-6-67		Park Lawn		Rockville, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Ernest C. Garther						Gaithersburg, Md.		DATE SEP 7 1967				

CERTIFICATE OF DEATH

12571

12580

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 9 d.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital		d. STREET ADDRESS 230 North B Street	
3 NAME OF DECEASED (Type or print) Ethel Maud Chilson		4 DATE OF DEATH Month Sept. Day 13 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1885 AGE (In years lost birthday) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At home	
11 BIRTHPLACE (County & State, or foreign country) England		12 CITIZEN OF WHAT COUNTRY? Amer.	
13 FATHER'S NAME Robinson		14 MOTHER'S MAIDEN NAME Not available	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 014 20 0586 B	
17. INFORMANT Hosp. Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Intestinal Obstruction DUE TO (c) Adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 9 days Enter 9 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Age - Old			19. WAS AUTOPS PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 4, 1967 , to Sept 13, 1967 , that (I) (we) last saw the deceased alive on Sept 12, 1967 , and that death occurred at 4 A.M. from causes and on the date stated above			
22a. SIGNATURE W.W. Eastman		22b. DATE SIGNED Sept 13 1967	
22c. PHYSICIAN'S NAME (Type) W.W. EASTMAN		22d. ADDRESS 831 University Blvd E Silver Sp. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 15, 1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Calver Manor Pk. Md
24. FUNERAL DIRECTOR J. Arthur Walter		25a. RECEIVED BY REG. STRAR SEP 18 1967	
25b. REGISTRAR'S SIGNATURE J. Arthur Walter		25c. REGISTRAR'S SIGNATURE J. Arthur Walter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to棺 papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12572

12581

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 514 Deerfield Avenue		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 514 Deerfield Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle CHOPNICK Last CHOPNICK		4. DATE OF DEATH Month Sept. Day 29 Year 1967	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?? 1897	
9. AGE (in years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furniture Retailer		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Aaron Chopnick		14. MOTHER'S MAIDEN NAME Sadie Snider	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Morris Miller		Address 509 Mansfield Rd, SSp, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon interstitial DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January, 1967 to September 27, 1967 , that (I) (we) last saw the deceased alive on Sept 26, 1967 , and that death occurred at 1200 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Blaine H. Eig		22b. DATE SIGNED Sept 28, 1967	
22c. PHYSICIAN'S NAME (Type) BLAINE H. EIG		22d. ADDRESS 2641 Colson Rd Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Natl. Mem. Park		23d. LOCATION (City, town or county) (State) Falls Church, Va.	
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th Street N.W.	
25a. REC'D BY REGISTRAR Oct 3 1967		25b. REGISTRAR'S SIGNATURE William Judge	

CERTIFICATE OF DEATH

12582

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Lycoming</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>1391 Almond Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>708 Rosemere Street Silver Spring, Md</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Clark</u> Last <u>Clark</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug. 4, 1897</u>
9. AGE (In years last birthday) yrs <u>70</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Pa.</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse J. Zigel</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-40-6930</u>	
17. INFORMANT <u>John C. Hoover</u>		Address <u>708 Rosemere Street SS, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4200</u> DUE TO (b) <u>with congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>67</u> , to <u>9/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/9</u> , 19 <u>67</u> , and that death occurred at <u>8:54</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>S. W. Nealon Jr.</u>		22b. DATE SIGNED <u>9/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. W. Nealon Jr.</u>		22d. ADDRESS <u>1746 K St N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>9/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Pleasant Cemetery Co.</u>		23d. LOCATION (City or Town) (County) (State) <u>Williamsport, Lycoming Pa.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
ADDRESS <u>8434 Georgia Ave S.S.</u>		25b. REGISTRAR'S SIGNATURE <u>John C. Hoover</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

12583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp</u>		d. STREET ADDRESS <u>1001. WADGE AVE</u>	
3 NAME OF DECEASED (Type or print) <u>THELMA A. CLARK</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>5/11/15</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Aaron Mills</u>		14. MOTHER'S MAIDEN NAME <u>Minnie J. Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perudent Lobular Pneumonia</u> DUE TO (b) <u>Bronchogenic Carcinoma; Right Lung</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u> <u>6 weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>5/11, 1967</u> to <u>9/25, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/25, 1967</u> and that death occurred at <u>5:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Pumphrey</u>		22b. DATE SIGNED <u>9/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT A. PUMPHREY</u>		22d. ADDRESS <u>809 Viers Mills Rd. Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-28-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. RECD BY REGISTRAR DATE <u>OCT 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12575

12584

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>620 Sligo Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Eugene W. CLARKE</u>		4 DATE OF DEATH <u>Sept 20 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-18-1873</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Coakey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-54-8821</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Upper Respiratory infection & bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>August</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>Aug 1</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>James R. Coleman MD</u>		22b. DATE SIGNED <u>9/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>		22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>SEPT. 23-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FAMILY</u>		23d. LOCATION (City or Town) (County) (State) <u>NINDE King George, Va</u>	
24. FUNERAL DIRECTOR <u>Blufford B. Redding</u>		25a. RECD BY REGISTRAR <u>Therese H. Redding</u>	
25b. REGISTRAR'S SIGNATURE <u>John Charles Justice</u>		DATE <u>SEP 22 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MONTGOMERY STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase									
c. LENGTH OF STAY IN 1b 2 months					d. STREET ADDRESS 6625 Hillandale Road									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oakhaven Convalescent Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Alfred Lee Combe					4. DATE OF DEATH Sept. 27 1967									
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4, 1886		9. AGE (in years last birthday) 80 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.								
13. FATHER'S NAME Paul Combe					14. MOTHER'S MAIDEN NAME Louise Monet									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 531-61-5145					17. INFORMANT William Combe, 4701 Willard Ave. Chevy Chase Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ascending Pyelonephritis 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of Prostate & Renal Obstruction & Multiple Osseous Metastases DUE TO (b) 2 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)														
21. I certify that Dr. Charles E. Woodson attended the deceased from Feb. 1967 to 9/27 1967 , that (I) (we) last saw the deceased alive on 9/26 1967 , and that death occurred at 8:27 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Charles E. Woodson M.D.					22b. DATE SIGNED 9/27/67									
22c. PHYSICIAN'S NAME (Type) CHARLES E. WOODSON					22d. ADDRESS 1801 Eye St. Wash. D.C. 20006									
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation					23b. DATE THEREOF 9-23-67					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				
23d. LOCATION (City, town or county) (State) Suitland, Maryland														
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR OCT 2 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18-20 Film 393
10-10-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12586

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>years.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7823 Custer Rd.</u>		e. STREET ADDRESS <u>7823-Custer Rd.</u>	
3 NAME OF DECEASED (Type or print) <u>Louise</u> First <u>Heider</u> Middle <u>Corry</u> Last		4 DATE OF DEATH Month <u>Sept</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 21, 1905</u>
9 AGE (in years last birthday) <u>61</u> yrs		FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Henry W. Heider</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Dernn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>577-52-3935</u>	
17 INFORMANT <u>Brother</u>		6301 <u>Biggs Road</u>	
<u>Carl A. Heider</u>		<u>Hyattsville, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Re: 9/11/79 - Barbiturate poisoning & drowning</u> DUE TO (b) <u>Overdose of barbiturates</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Took overdose of barbiturates and submerged in bath tub</u>	
20c. TIME OF INJURY Month, Day, year <u>7 ?</u> <u>XX</u> <u>Sept 27 19 67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect an <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) <u>Washington, D. C.</u> (County) (State)
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPERY, Bethesda, Maryland</u>		25a. REC'D By REGISTRAR <u>OCT 3 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

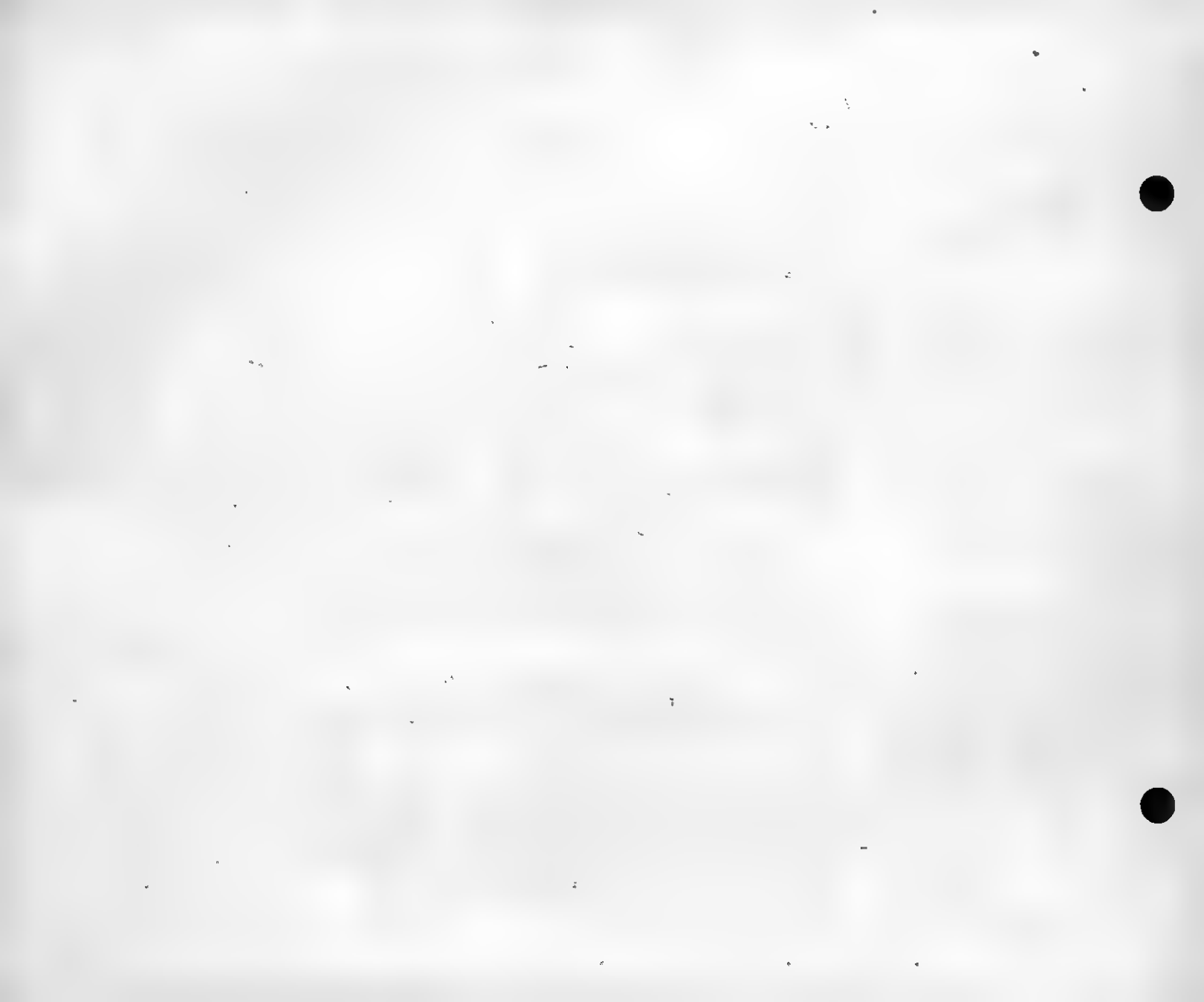
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12587

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>1 1/2 hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>Section House 4, 1053 Buchanan - NE</i>	
3 NAME OF DECEASED (Type or print) <i>Sister Mary Rose Cratow</i>		4 DATE OF DEATH Month <i>September</i> Day <i>21</i> Year <i>67</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <i>May 1st - 1936</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 AGE in years last birthday <i>31</i> yrs	F UNDER 1 YEAR Months Days Hours IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>RD - Medical Student</i>		10b KIND OF BUSINESS OR INDUSTRY <i>Student</i>	
11 BIRTHPLACE (State or foreign country) <i>Sherbrooke - Quebec</i>		12 CITIZEN OF WHAT COUNTRY? <i>Canada</i>	
13 FATHER'S NAME <i>Laurel Cratow</i>		14 MOTHER'S MAIDEN NAME <i>Rose Fortin</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <i>Sister Mary Rose Cratow</i>		Address <i>Suburban Hospital</i>	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. <i>194</i> IMMEDIATE CAUSE (a) <i>Multiple Extreme Injuries</i> DUE TO (b) <i>with Internal Hemorrhage</i> DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Deceased, passenger, was thrown from auto which hit railroad tracks and overturned.</i>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Deceased, passenger, was thrown from auto which hit railroad tracks and overturned.</i>	
20c TIME OF INJURY Month, Day, Year <i>6:52 PM 9-21-67</i>		20d PLACE OF INJURY (Home, farm, factory, street, office, business) <i>Street</i>	
20e (City or town) <i>Rockville</i>		20f (County) <i>Montgomery</i>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP, M.D.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i>		23b DATE THEREOF <i>9/23/67</i>	
23c NAME OF CEMETERY OR CREMATORY <i>Eastern Cemetery</i>		23d LOCATION (City or town) (County) (State) <i>Montreal, Canada</i>	
24. FUNERAL DIRECTOR <i>Jas. T. Ryan, Inc.</i>		25a REC'D BY REGISTRAR <i>SEP 25 1967</i>	
ADDRESS <i>317 Pa. Ave., SE DC3</i>		25b REGISTRAR'S SIGNATURE <i>James J. Ryan</i>	



CERTIFICATE OF DEATH

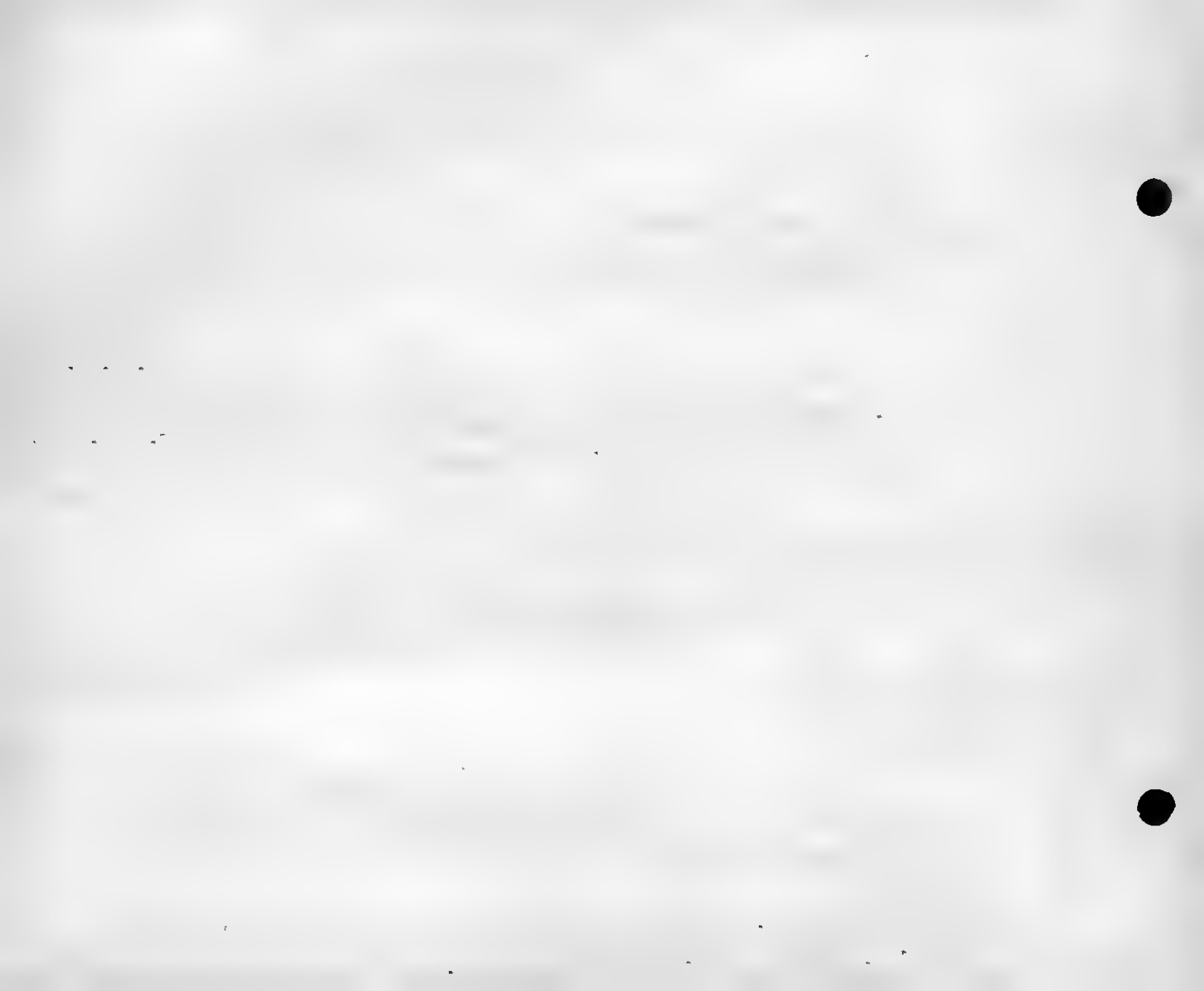
12579

12588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN Hospital</u>		d. STREET ADDRESS <u>3108 PARKER AVE</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Catherine Davenport</u> First Middle Last		4. DATE OF DEATH Month <u>SEPT</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-14</u> 9. AGE (In years last birthday) <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.H. INT. RESEARCH</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Hiram E. Heckrott</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Spedden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>579-10-6188</u>	
17. INFORMANT <u>JAMES R. DAVENPORT - Husband -</u>		Address <u>3108 Parker Ave. Sil. Spr. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Adenocarcinoma of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/63</u> , 19 to <u>9/26/67</u> , 19, that (I) (we) last saw the deceased alive on <u>9/25/67</u> , 19, and that death occurred at <u>3:20</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>9/26/67</u>
22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD</u>		22d. ADDRESS <u>5413 Cedarlane Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>John E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
Address <u>8434 Georgia Avenue Silver Spring, Md.</u>		DATE <u>OCT 2 1967</u>	



CERTIFICATE OF DEATH

12589

12580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Approved by the Medical Examiner

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in lb <u>3 Hours</u>		d. STREET ADDRESS <u>2019 Hanover St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>CLIFFORD A. DAVIS</u>		4. DATE OF DEATH <u>9-1</u> 19 <u>67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-3-08</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Electric</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>Clay V. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Sidney Rochester</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>577-07-8618</u>	17. INFORMANT Address <u>Mrs. Dorothy C. Davis 2019 Hanover Street</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO <u>thrombosis left coronary artery</u> DUE TO <u>coronary artery sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u> <u>?</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>63</u> , to <u>9/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/1</u> , 19 <u>67</u> , and that death occurred at <u>1:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>K F Kreuzburg</u>		22d. ADDRESS <u>7852-1666 N.W. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Montgomery Md.</u>
24 FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
Warner E. Pumphrey Inc. 8434 Georgia Avenue SS		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

12581

12590

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> c. LENGTH OF STAY IN 1b <u>24 days/Hours</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
3. NAME OF DECEASED (Type or print) <u>Nicholas Schellian DeLorse</u> First Middle Last		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> *SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1889</u> 9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done, do not list of working title, even if retired) <u>Retired Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>
13. FATHER'S NAME <u>Theodore DeLorse</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Schillian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial and pulmonary failure</u> DUE TO (b) <u>Peritonitis following resection</u> DUE TO (c) <u>of sigmoid colon for adenocarcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 1533 19. INTERVAL BETWEEN ONSET AND DEATH <u>3 days uncertain</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis, severe.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-1</u> , 19 <u>67</u> , to <u>9-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-25</u> , 19 <u>67</u> , and that death occurred at <u>6:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>H. S. Siddle</u>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Wellsville New York</u>
24. FUNERAL HOME <u>W. K. HUNT & Son Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

12582

12591

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>West D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oathesda Silver Nursing Home</u>		d. STREET ADDRESS <u>6313 16th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Dominitz</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Hebrew</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESLADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHAN SOROKO</u>		14. MOTHER'S MAIDEN NAME <u>EVA WEIZMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-14-0774</u>	
17. INFORMANT <u>614 Collesboro Road, Rockville, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>110X</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Home</u> , 19 <u>45</u> , to <u>Sept 7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 4</u> , 19 <u>67</u> , and that death occurred on <u>Sept 7</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Blaine H. Eig</u>		22b. DATE SIGNED <u>Sept 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG</u>		22d. ADDRESS <u>6641 Collesboro Rd, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-10-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>NORFOLK VA.</u>
24. FUNERAL DIRECTOR <u>Hebrew Cemetery</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared by Dr. Reed

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12583

CERTIFICATE OF DEATH

12592

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRINGS		c. LENGTH OF STAY IN 1b 14 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIMPSONVILLE		d. STREET ADDRESS 117 VISTA ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN R. DORSEY		4. DATE OF DEATH Month 9 Day 18 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/36
9. AGE (In years lost birthday) 31 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIST		10b. KIND OF BUSINESS OR INDUSTRY DEPT. OF DEFENSE	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN RALPH DORSEY		14. MOTHER'S MAIDEN NAME LOUISE FOX	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT Mrs NANCY DORSEY		Address 117 VISTA ROAD	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO (b) Brain' Skull Swelling DUE TO (c) Acoustic neuroma		INTERVAL BETWEEN ONSET AND DEATH 14 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		49. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/4 , 19 67 , to 9/18 , 19 67 that (I) (we) last saw the deceased alive on 9/18 , 19 67 , and that death occurred at 3 PM from causes and on the date stated above.			
22a. SIGNATURE John I. Reed		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John I. Reed		22d. ADDRESS 1015 Spring St Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF SEPT. 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY LODON PARK		23d. LOCATION (City or Town) (County) (State) BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR HARRY WITZKE		ADDRESS COLUMBIA PIKE ELYCOTT CITY MD.	
25a. REC'D BY REGISTRAR SEP 21 1967		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10/19/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 35minutes d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL				2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG d. STREET ADDRESS RT 2 Box 114 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VIRGIL OSWALD DOVE				4. DATE OF DEATH Month 9 Day 29 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-7-06	
9. AGE (In years last birthday) 61 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LANDSCAPE GARDENER		10b. KIND OF BUSINESS OR INDUSTRY Garden-Landscape		11. BIRTHPLACE (County & State, or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME BENJAMIN DOVE			
14. MOTHER'S MAIDEN NAME SARAH LOWRY				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO. 579-09-8339				17. INFORMANT Mrs. Virgil O. Dove Address Same 95			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Severe generalized arteriosclerosis DUE TO (c) gro. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201						INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 Sept. 29, 1967 , that (I) (we) last saw the deceased alive on Sept 29, 1967 , and that death occurred at 11:55PM , from causes and on the date stated above.							
22a. SIGNATURE Friedrich Moomau M.D.				22b. DATE SIGNED 9-29-67		22c. PHYSICIAN'S NAME (Type) Dr. F. Moomau	
22d. ADDRESS Medical center, Sandy Spring, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 10-2-67		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville Mont. Md.			
24. FUNERAL DIRECTOR Francis H. Barber				25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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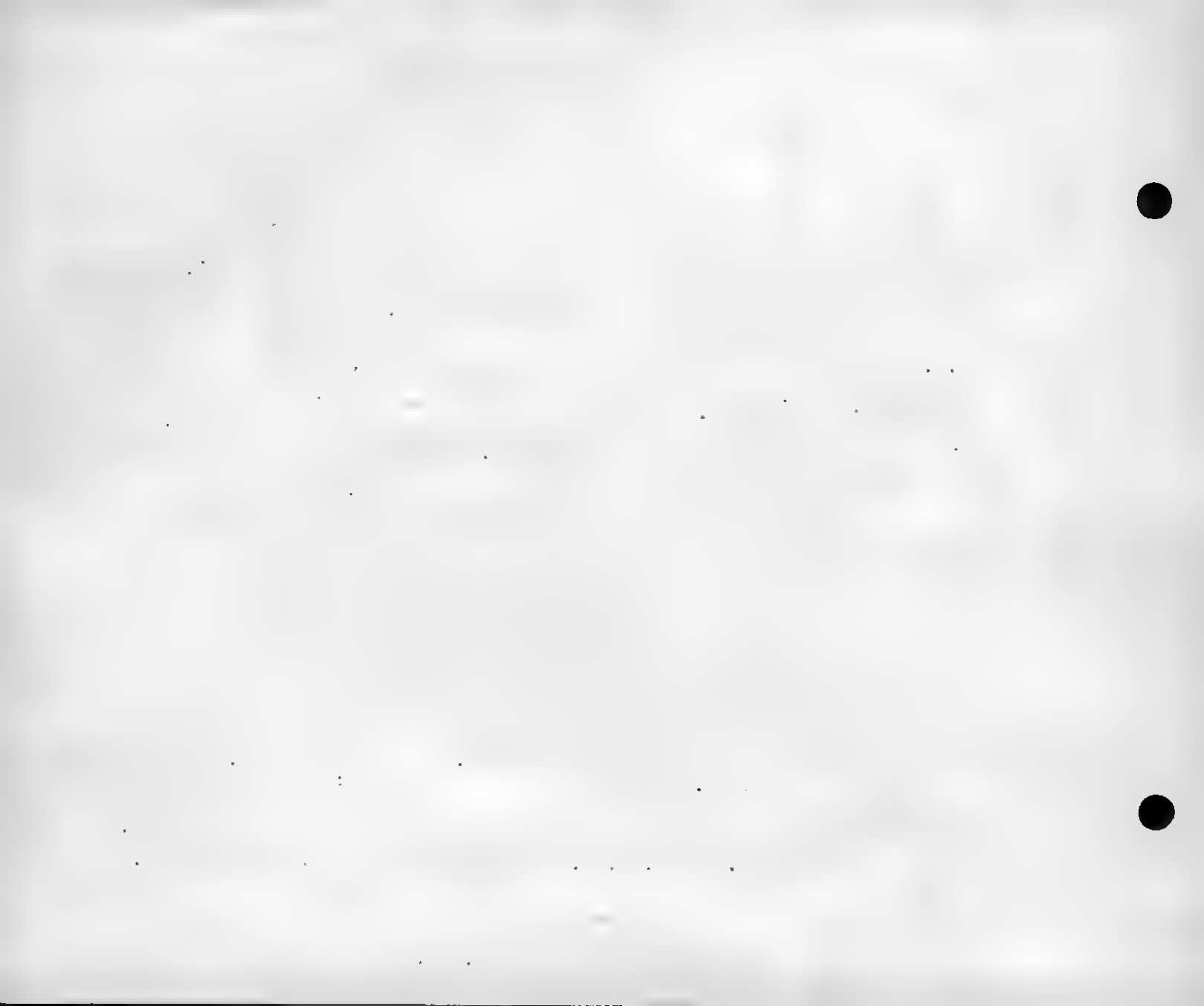
CERTIFICATE OF DEATH

12594

12585		12594	
a. PLACE OF DEATH b. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE Kansas b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 138 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clay Center		d. STREET ADDRESS 717 Court Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Bert E		4. DATE OF DEATH Month Sept. Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1946
9. AGE (In years lost birthday) yrs 21		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Clay Center, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bert E. Downing jr.		14. MOTHER'S MAIDEN NAME Betty Lou Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1965-1967		16. SOCIAL SECURITY NO 515 50 0503	
17. INFORMANT Mr. R Bert E Downing		Address Kansas 717 Court Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 178X IMMEDIATE CAUSE (a) Embryonal carcinoma of testis with widespread metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Apr. 29 , 1967, to Sept. 14 , 1967, and that death occurred at 1:50 PM , from causes and on the date stated above			
22a. SIGNATURE <i>Lawrence A. Jones</i>		22b. DATE SIGNED Sept. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence A. Jones, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL (REMOVAL, CREMATION) (Specify) Burial		23b. DATE THEREOF 9-18-1967	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or Town) (County) (State) Clay Center Kansas	
24. FUNERAL DIRECTOR Falls Church Funeral Home, 1102 West Broad Street, Falls Church, Va		25a. RECD BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 6&21 Film 393
10-5-67 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12586

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12595

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2121 1/2 Ave. + Ho Jr</u>				d. STREET ADDRESS <u>12426 Feldon St.</u>			
3 NAME OF DECEASED (Type or print) <u>Samuel Hartford Downs</u> First Middle Last				4 DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1967</u>			
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6-13-30</u>		9 AGE (In years last birthday) <u>37</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager of Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vending Company</u>		11 BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>Samuel H. Downs Sr</u>				14 MOTHER'S MAIDEN NAME <u>Ann Gathright</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>yes</u>		17 INFORMANT <u>Jean L. Downs</u> Address <u>12426 Feldon Street Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> <u>Acute coronary thrombosis</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						9 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22 DATE SIGNED <u>9-19-1967</u>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				Address (City or town) (County) (State) <u>Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Sept. 22, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Prince Georges Co., Md.</u>	
23a. <u>Burial</u>		23b. <u>Sept. 22, 1967</u>		23c. <u>Fort Lincoln Cemetery</u>		23d. <u>Prince Georges Co., Md.</u>	
23a. <u>Warner E. Pumphrey, Inc.</u>		23b. <u>8414 Georgia Ave.</u>		23c. <u>Silver Spring, Md.</u>		23d. <u>SEP 22 1967</u>	
25a. RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <u>J. E. Jones</u>			



CERTIFICATE OF DEATH

12587

12596

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
c. LENGTH OF STAY IN 1b 30 days		d. STREET ADDRESS 328 BOYD AVE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Colonial Villa Nursing Home		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MARY ENMA Dungan		4. DATE OF DEATH 9-7-1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-1888
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR: Months 7 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Hutchings		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 146-01-30738	
17. INFORMANT Mrs. Donald A. Dungan		Address 328 Boyd Ave Takoma Park	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Cerebral thrombosis, congestive heart failure			
DUE TO (b) Arteriosclerotic cardio-vascular disease			
DUE TO (c) unknown			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1967 , to Sept. 7, 1967 , that (I) (we) last saw the deceased alive on Sept. 5, 1967 , and that death occurred at 4:06 AM , from causes and on the date stated above			
22a SIGNATURE Eino Magi		22b DATE SIGNED 9-7-67	
22c PHYSICIAN'S NAME (Type) EINO MAGI		22d ADDRESS 831 Univ. Blvd. E., Silver Spring, Md.	
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF Sept 11-1967	
23c NAME OF CEMETERY OR CREMATORY Adventist National		23d LOCATION (City or Town) (County) (State) Arlington	
24. FUNERAL DIRECTOR Arthur Waller, Takoma Funeral Home		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1, 2 and 3 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/6

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12583

CERTIFICATE OF DEATH

12597

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>2 weeks</u>	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cherry Chase</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>4315 Deland St.</u>	
3 NAME OF DECEASED (Type or print) <u>Lottie B. Duquette</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10, 1834</u>
9 AGE (in years last birthday) <u>83 yrs</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Thomas B. Shaw</u>		14 MOTHER'S MAIDEN NAME <u>Alla Hardwick</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16 SOCIAL SECURITY NO	
17 INFORMANT <u>husband</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>incarcerated femoral hernia, right</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>TWK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/17</u> , 19 <u>67</u> to <u>9/28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/21</u> , 19 <u>67</u> and that death occurred <u>9/28</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>E. Levin</u>		22b. DATE SIGNED <u>9/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. LEVIN</u>		22d. ADDRESS <u>8218 Wisconsin, Bethesda</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
24 FUNERAL DIRECTOR <u>ROBERT A. TUNNEY, Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>OCT 3 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12588

12588

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner - Dr. [Signature]

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN IB <u>I.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>8701-McLure Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Bernard Blakeman Eddy</u> First Middle Last				4. DATE OF DEATH <u>Sept 11</u> 19 <u>67</u> Month Day Year						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Sept 15, 1902</u>		9. AGE (In years last birthday) <u>64</u> yrs IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Bernard Eddy</u>				14. MOTHER'S MAIDEN NAME <u>Grace Blakeman</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes U.S. Army</u>				16. SOCIAL SECURITY NO. <u>577-32-1186</u>		17. INFORMANT <u>Arthur Eddy</u> Address <u>As above</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CARDIAC ARREST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>								INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>7 YEARS</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIAbetes MELLITUS</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>SEPT 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>SEPT 3</u> , 19 <u>67</u> , and that death occurred at <u>6:27</u> M, from causes and on the date stated above.										
22a. SIGNATURE <u>Thomas F. O'Connor</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/17/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u>						22d. ADDRESS <u>5218 WISCONSIN AVE BETHESDA</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>9-14-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>SEP 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

12590

CERTIFICATE OF DEATH

12590

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmoreland Hills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5301 Carvel Road		d. STREET ADDRESS 5301 Carvel Road	
3. NAME OF DECEASED (Type or print) PAUL EDGAR ELICKER First Middle Last		4. DATE OF DEATH Sept. 14, 1967 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1894
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ch. D.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Graybill, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Elicker		14. MOTHER'S MAIDEN NAME Elizabeth Kuhl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.	
17. INFORMANT Wife Elsie Elicker		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: 331X Cerebral Vascular Accident IMMEDIATE CAUSE (a) DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 1944, 19 to 9/14, 1967 , that (I) (we) last saw the deceased alive on 9/13, 1967 , and that death occurred at 11:15 M, from causes and on the date stated above.			
22a. SIGNATURE A. F. Kreglow		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) A. F. KREGLOW		22d. ADDRESS 4900 Indian Lane Spring Valley, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-67	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Reformed	23d. LOCATION (City or Town) (County) (State) Spring Grove, Penna.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY Funeral Home		25a. REC'D BY REGISTRAR SEP 20 1967	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12591

12600

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		d. STREET ADDRESS <u>8105 Hammond Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Henry Thomas ELLIOTT</u>				4. DATE OF DEATH <u>Sept. 26 1967</u>			
5 SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-88</u>	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u>	
13. FATHER'S NAME <u>Walter Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Albright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-34-8212</u>		17. INFORMANT <u>A Hospital Record</u> Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Arteriosclerosis Obliterans</u> DUE TO (c) <u>Arteriosclerosis Obliterans</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>hours</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>67</u> , to <u>9/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> 19 <u>67</u> and that death occurred at <u>11:39 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>K. Cruze</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENNETH CRUZE</u>				22d. ADDRESS <u>University Blvd E. Delmar, Del.</u>			
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 29-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Acc. Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Ridge Rd. P. O. Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REG. SEAL <u>SEP 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12592

CERTIFICATE OF DEATH

12661

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>31 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		d. STREET ADDRESS <u>8317 Cartridge Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. SAN. & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Percy Elliott</u>		4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>20-28-1946</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Body Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Motive</u>	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Elliott</u>		14. MOTHER'S MAIDEN NAME <u>Leake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-18-3444</u>	
17 INFORMANT <u>Gertrude L. Elliott</u> Address <u>402 Clayborn Tr. Pk.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus with perforation</u> DUE TO (b) <u>Bilateral pneumonia</u> DUE TO (c) <u>Ref.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 11 - 14, 1967</u> , to <u>SEPT. 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept. 12, 1967</u> , and that death occurred at <u>9 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Albert H. Grollman</u> M.D.		22b. DATE SIGNED <u>9-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN, M.D.</u>		22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 15, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union</u>		23d. LOCATION (City or Town) (County) (State) <u>Burtonsville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>R. Thomas Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Ga. Ave., S.S. Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12552

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital		e STREET ADDRESS Route #2, Box 25-FA	
3 NAME OF DECEASED (Type or print) First John Middle Paul Last ELLIS		4 DATE OF DEATH Month September Day 11 Year 19 67	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 8, 1967
9 AGE (In years lost birthday) yrs 3		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13 FATHER'S NAME Howard R. Ellis		12 CITIZEN OF WHAT COUNTRY? USA	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO N/A	
17. INFORMANT Howard R. Ellis, Route #2, Box 25-FA		Address Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital heart defect 1075 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Sept. 10 , 19 67 , to Sept. 11 , 19 67 , that (X) (we) last saw the deceased alive on Sept. 11 , 19 67 , and that death occurred at 6:40 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Franklin K. Loeb</i> FRANKLIN K. LOEB M.D.		22b. DATE SIGNED Sept. 12, 1967	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasevic, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-13-67	23c NAME OF CEMETERY OR CREMATORY St. Paul's Methodist Seminary	23d LOCATION (City or Town) (County) (State) Leonardtwn Md.
24. FUNERAL DIRECTOR Mattingly Funeral Home Leonardtwn, Maryland		25a REC'D BY REGISTRAR DATE SEP 14 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CERTIFICATE OF DEATH

12594

12603

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		d. STREET ADDRESS 326 Grove Avenue	
3 NAME OF DECEASED (Type or print) First Clarence Middle Raymond Last Eskildsen		4. DATE OF DEATH Month September Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) 53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrator		10b. KIND OF BUSINESS OR INDUSTRY Federal Government	
11 BIRTHPLACE (County & State, or foreign country) Minnesota		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Kristen Eskildsen		14. MOTHER'S MAIDEN NAME Hansine Lund	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1941-1945		16 SOCIAL SECURITY NO Not available	
17 INFORMANT The Medical Records		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral hemorrhagic bronchopneumonia DUE TO (b) Gram negative septicemia DUE TO (c) Acute myelogenous leukemia	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) A[Acute renal failure. B[Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1 week 1 month	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) 25
21. I certify that I (this hospital) attended the deceased from September 2 19 67 , to September 2 19 67 that I (we) last saw the deceased alive on September 25 19 67 , and that death occurred at 2:25 AM , from causes and on the date stated above.			
22a. SIGNATURE David L. Lilien		22b. DATE SIGNED 25 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) David L. Lilien, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 27, 67	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia
24. FUNERAL DIRECTOR Covington-Martin Funeral Home		25a. REC'D BY REGISTRAR SEP 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12604

1 PLACE OF DEATH a. COUNTY MONTGOMERY b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (rural) c LENGTH OF STAY IN lb 4 days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE MARYLAND b COUNTY VIRGINIA c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRFAX	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d STREET ADDRESS 12508 BRADDOCK RD. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) VADA First Middle Last P FERGUSON		4 DATE OF DEATH Month Day Year SEPT. 19 1967	
5 SEX FEMALE	6 COLOR OR RACE CAUC	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1897 17 APRIL 1887
9 AGE (in years lost birthday) 77 7/10 yrs		IF UNDER 1 YEAR Months Days Hours Min. 7 7 70	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) WILKES BARRE, N.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME LEE PARSONS		14 MOTHER'S MAIDEN NAME JULIA CHURCH	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT CHARLOTTE BLEVINS		Address 12508 BRADDOCK RD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 463X IMMEDIATE CAUSE (a) Pulmonary embolus, massive DUE TO (b) Thrombophlebitis, legs, deep DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 15 SEPT., 1967 , to 19 SEPT., 1967 , that (I) (we) last saw the deceased alive on 19 SEPT. 1967 , and that death occurred at 3 P.M. from causes and on the date stated above.			
22a SIGNATURE <i>Lawrence W. Raymond</i>		22b. DATE SIGNED 20 Sept. 1967	
22c PHYSICIAN'S NAME (Type) Lawrence W. Raymond, M.D.		22d ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY THOMAS BRIDGE CEMETERY	23d LOCATION (City or Town) (County) (State) MARION VA.
24 FUNERAL DIRECTOR BARNETT'S FUNERAL HOME		25a REC'D BY REGISTRAR SEP 27 1967 DATE	
25b REGISTRAR'S SIGNATURE <i>John Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12596

CERTIFICATE OF DEATH

12605

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN Tb <u>22 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>212 St. Lawrence Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Henry</u> Last <u>Fillius</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-9-04</u>
9. AGE (in years last birthday) <u>63 yrs</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Milton J. Fillius</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Speiser</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>213-09-8127</u>	
17. INFORMANT <u>Maud G. Fillius</u>		18. ADDRESS <u>212 St. Lawrence Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO (b) <u>Adenocarcinoma of colon with</u> DUE TO (c) <u>massive liver metastases.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-1-67</u> , 1967, to <u>9/25</u> , 1967, that (I) (we) last saw the deceased alive on <u>9/18</u> , 1967, and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u> M.D.		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVA (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince George Co. Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

Cleared with Medical Examiner - Dr. B. Repp. 9/25/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12597		CERTIFICATE OF DEATH	
12606			
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN It Colonial Villa Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 807 Butternut Street, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ellen Edith Firor		4 DATE OF DEATH Month Sept. Day 12 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 6, 1880
9 AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months 87 Days 0 Hours 0 Min. 0	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Belvedere, New Jersey		12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Bittenbender		14. MOTHER'S MAIDEN NAME Agnes Bittenbender LITZENBERGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 320-03-2028-B	
17 INFORMANT Patient's Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) 481X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive failure (c) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH Sudden abnormal heart			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/11 , 19 67 , to 9/12 , 19 67 , that (I) (we) last saw the deceased alive on 9/11 , 19 67 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE Chas H Voloshin		22b. DATE SIGNED 9/12/1967	
22c. PHYSICIAN'S NAME (Type) Chas H Voloshin		22d ADDRESS 831 University Blvd E. Sd. of Md	
23a BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b DATE THEREOF Sept 15, 1967	23c NAME OF CEMETERY OR CREMATORY Cedar Hill Mausoleum	23d LOCATION (City or town) (County) (State) Suitland, Prince Georges Co. Md
24. FUNERAL DIRECTOR Arthur Walters, 254 Carroll St NW DC		25a REC'D BY REGISTRAR SEP 18 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

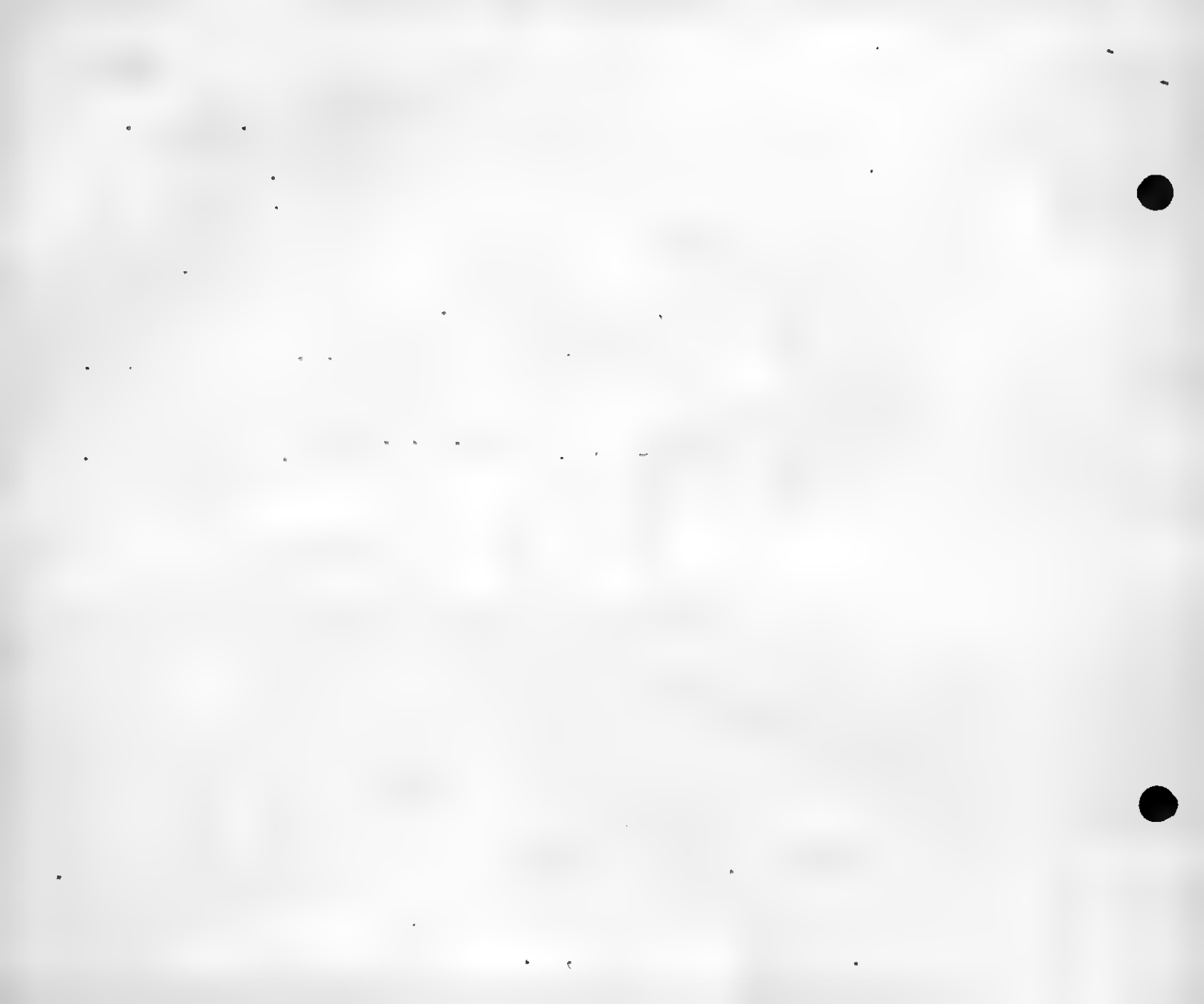
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12607

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived) (Institution Residence before admission) b. STATE Maryland c. COUNTY Montg. 11100 Ralston Rd.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Marylander		d. STREET ADDRESS 11100 Ralston Road	
3 NAME OF DECEASED (Type or print) KATIE		4 DATE OF DEATH Sept. 1, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Feb. 26, 1881
9 AGE (in years) 85 lost birthday yrs		10 UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS <input type="checkbox"/> Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11 BIRTHPLACE (State or foreign country) Conway, S.C.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME James O'Gilrie		14. MOTHER'S MAIDEN NAME Emma O'Gilrie	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212-54-7321	
17 INFORMANT R.H. Mitchell		Address 11100 Ralston Rd. Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY. 4201 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute DUE TO (b) Cardio Vascular Disease DUE TO (c) 		INTERVAL BETWEEN DEATH AND DEATH 3 hr. years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		22. DATE SIGNED 9-1-67	
EXAMINER'S NAME (Type) JOHN G. BALL		Address (Street, city, town or county) Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL, or other disposition Burial-Transit 9/1/67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cem.		23d. LOCATION (City or town) (County) (State) New Bern, North Carolina	
24 FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Md.		25a. REC'D BY REGISTRAR SEP 8 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12593

12608

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cherry Chase</u>		c LENGTH OF STAY IN 1b <u>4 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7208 Brennon Lane</u>		d STREET ADDRESS <u>7208 Brennon Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Clara</u> First Middle Last <u>Forbush</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/3/96</u>
9a USUAL OCCUPATION (Give kind of work done but not past of working life, even if retired) <u>MUSICIAN</u>		9b KIND OF BUSINESS OR INDUSTRY <u>MUSICIAN</u>	9c AGE (In years last birthday) <u>70</u> yrs
10a USUAL OCCUPATION (Give kind of work done but not past of working life, even if retired) <u>MUSICIAN</u>		10b KIND OF BUSINESS OR INDUSTRY <u>MUSICIAN</u>	10c BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>
11 CITIZEN OF WHAT COUNTRY? <u>USA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>ERIC LUNDELL</u>		14 MOTHER'S MAIDEN NAME <u>WILHEMINA JOHNSON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>SCOTT E. FORBUSH 7208 BRENNON</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Adenocarcinoma, left breast</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>years -</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MED. EXAMINER <input checked="" type="checkbox"/> <u>9/28/67</u>	
		Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>9-27-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>LEISURE CREMATORY</u>	23d LOCATION (City or town) (County) (State) <u>WASHINGTON D.C.</u>
24 FUNERAL DIRECTOR <u>LEE FUNERAL HOME 300 4 ST NW</u>		25a REC'D BY REGISTRAR <u>OCT 2 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12600

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>64 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>9604-Bulks Lane Park</u>	
3 NAME OF DECEASED (Type or print) <u>James H. Fox</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/14/23</u>
9 AGE (in years, last, b. day) <u>44</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. J.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>M.I.H.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Phila Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>R. Maurice Fox</u>	
14. MOTHER'S MAIDEN NAME <u>Berger Van der Linden</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>	
16. SOCIAL SECURITY NO. <u>189-16-3156</u>		17. INFORMANT Address <u>Wife Rita Fox (Same as above)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4221 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>63</u> , to <u>Sept 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 17</u> , 19 <u>67</u> , and that death occurred at <u>9:25</u> P.M. from causes on the date stated above.			
22a. SIGNATURE <u>Robert N. Coale</u> M.D.		22b. DATE SIGNED <u>Sept 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>		22d. ADDRESS <u>4429 Bradley Lane, Chevy Chase, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>9-20-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or town) (County) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12601

CERTIFICATE OF DEATH

12610

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>North Carolina</u> b. COUNTY <u>Forsyth</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keenersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Linville Ct. B #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gustav E. Friedenberg</u> First Middle Last				4. DATE OF DEATH <u>Sept 23</u> 19 <u>67</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17, 1898</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERGYMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward FRIEDENBERG</u>				14. MOTHER'S MAIDEN NAME <u>Julia Kuyuth</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Don-Walter Friedenberg, Beth. Md.</u> Address <u>5608bma Ct.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Cerebrovascular occlusion</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 18, 1967</u> to <u>Sept 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 21, 1967</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Stanley M. Bialack</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STANLEY M. BIALACK</u>				22d. ADDRESS <u>8218 Wisconsin Ave. Beth. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>9/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		23d. LOCATION (City or town) (County) (State) <u>SUITLAND, MD.</u>	
24. FUNERAL DIRECTOR <u>JOS. GAWLER'S SONS, 5130 WIS. AVE., N.W., WASHINGTON, D.C.</u>				25a. REC'D BY REGISTRAR <u>SEP 27 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12611

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3, Page 1.

5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Resident before admission) a STATE Maryland b COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.		c LENGTH OF STAY N 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e STREET ADDRESS 3027 Kramer St.	
3 NAME OF DECEASED (Type or print) Mary Rebecca Furcolow		4 DATE OF DEATH Month 18 Day Sept Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11, Feb, 25
9 AGE (In years last birthday) 42 yrs		10 UNDER 1 YEAR Months 4 Days 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Mississippi		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13 FATHER'S NAME LeRoy Mc Ewen		14 MOTHER'S MAIDEN NAME Edris Gilmore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 432-34-0493	
17 INFORMANT William H. Furcolow		Address 3027 Kramer Street Wheaton, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Insufficiency DUE TO Coronary Artery Heart Disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. 19 pm		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Keap M.D.		22. DATE SIGNED 9/19/1967	
EXAMINER'S NAME (Type) BELDEN R. KEAP, M.D.		DEPUTY MEDICAL EXAMINER address (Street, city town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Sept. 20, 1967	23c NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d LOCATION (City or town) (County) (State) Silver Spring, Maryland
24 FUNERAL DIRECTOR W. B. Thomas		25a RECD BY REG-STRAR SEP 22 1967	
25b REG-STRAR'S SIGNATURE Warner E. Humphrey, Inc.		25c ADDRESS 8434 Georgia Ave. Silver Spring, Md.	

12603

Item #9 Film #G393 10/11/67 ph

CERTIFICATE OF DEATH

12612

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sil. Sprg. Md. c. LENGTH OF STAY IN 1b 1 hr		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospt.		d. STREET ADDRESS 10721 Meadowhill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Vernell H Giebel		4 DATE OF DEATH Month Day Year 9 27 19 67	
5. SEX F	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/27/98 9 AGE (In years last birthday) 68/69 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Kentucky 12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME ? Reynolds		14. MOTHER'S MAIDEN NAME May Estes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Holy Cross 1500 Forest Glen Rd. SSMD.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subarachnoid hemorrhage, rupture of 350X DUE TO (b) intracranial aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr , 1967, to 27 Sept. , 1967, that (I) (we) last saw the deceased alive on 7 Sept. , 1967, and that death occurred at 11 A M. , from causes and on the date stated above.			
22a. SIGNATURE Robert T. Kelley M.D.		22b. DATE SIGNED 27 Sept 67	
22c. PHYSICIAN'S NAME (Type) ROBERT T. KELLEY M.D.		22d. ADDRESS 1302-18TH ST. N.W. WASH. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-30-67	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	23d. LOCATION (City or Town) (County) (State) SILVER SPRING MD.
24. FUNERAL DIRECTOR Thomas B. Harlan		25a. REC'D BY REGISTRAR DATE 10/15/67 25b. REGISTRAR'S SIGNATURE J. J. Jones	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12613

12604

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	c. LENGTH OF STAY IN 1b <u>10 1/2 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>200 Martins Lane</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>ALLEN</u> Middle <u>R</u> Last <u>Gilmore</u>		4 DATE OF DEATH Month <u>SEPT</u> Day <u>8</u> Year <u>19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-18-95</u> 9. AGE (In years last birthday) <u>72</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Abraham Gilmore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Adenocarcinoma of prostate</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> , 19 <u>67</u> , to <u>9/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/7/68</u> 19 <u>67</u> , and that death occurred at <u>1A</u> M, from causes and on the date stated above.		
22a. SIGNATURE <u>Ronald W. Barr</u>	M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>RONALD W. BARR</u>	22d. ADDRESS <u>10461 OLD GEORGETOWN RD BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Sept. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>
23d. LOCATION (City or Town) (County) (State) <u>Rockville Monty. Md.</u>		
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>12605 Item #2a, b, c & d Form #552-9/15/67</p> </div> <div> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>12614</p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u></p> <p>c. LENGTH OF STAY IN 1b <u>15 days</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)</p> <p>a. STATE <u>MD</u> D.C. b. COUNTY <u>MONTGOMERY CO.</u></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u></p> <p>d. STREET ADDRESS <u>8101 - 15th St</u> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>ISAAC "IKE"</u> Middle <u>GOLDBLATT</u> Last <u>GOLDBLATT</u></p>				<p>4. DATE OF DEATH</p> <p>Month <u>SEPT</u> Day <u>12</u> Year <u>1967</u></p>							
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>WHITE</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>7/4/78</u></p>		<p>9. AGE (in years last birthday) <u>89</u> yrs.</p>		<p>IF UNDER 1 YEAR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>motion picture operator</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>PICTURES</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>AUSTRIA</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>MAX JACOB GOLDBLATT</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>LIMANOWITZ</u></p>							
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO. <u>053-34-9084</u></p>		<p>17. INFORMANT <u>MILK J. GOLDBLATT-Son</u></p>		<p>Address <u>6101 - 86th ST. N. W.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Vascular Accident</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis Scurged</u></p> <p>(c) <u></u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>After traumatic Sp. (L) hip</u></p>											
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Yes (L) hip</u></p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell (L) hip</u></p>							
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. <u>8/20/67</u> p.m. <u>7:30</u></p>				<p>20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>money home</u></p>		<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>8/20/67</u> to <u>9/12</u>, 19<u>67</u> that (I) (we) last saw the deceased alive on <u>9/11</u> 19<u>67</u> and that death occurred at <u>7:30 PM</u> from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE <u>Boyd J. Schenck</u></p>				<p>22b. DATE SIGNED <u>9/13/67</u></p>							
<p>22c. PHYSICIAN'S NAME (Type) <u>GOLDBERG</u></p>				<p>22d. ADDRESS <u>4217 - 9th St. N.W.</u></p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>				<p>23b. DATE THEREOF <u>9/13/67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>UNION FIELDS CEM. QUEENS</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>NY</u></p>			
<p>24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u></p>				<p>25a. REC'D BY REGISTRAR <u>SEP 14 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u></p>					

MEDICAL CERTIFICATION



CERTIFICATE OF DEATH

12606

12615

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
c. LENGTH OF STAY IN 1b <u>1 yr 9 1/2 mo.</u>		d. STREET ADDRESS <u>5303 38 Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>L.</u> Last <u>COVER</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Leitch</u>		14. MOTHER'S MAIDEN NAME <u>Annie Dorsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-83990X</u>	
17. INFORMANT <u>Elizabeth Neagy University Park Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 19</u> , 19 <u>67</u> , to <u>9/1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8/31</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.F. Kreuzburg</u>		22d. ADDRESS <u>7852 16th Ave Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Friendship Md</u>	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12607

CERTIFICATE OF DEATH

12616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b 1 month d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4 d. STREET ADDRESS 517 Buchanan St., NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William Thomas Green First Middle Last		4 DATE OF DEATH Month Day Year 5 1967	
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Washington, DC	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ada Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Wash.	
17. INFORMANT Mrs. Wm. Green-517 Buchanan St., NW, DC		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 35ix (c) Urinary Infection		INTERVAL BETWEEN ONSET AND DEATH one month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Urinary Infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/21 , 19 67 , to 9/5 , 19 67 that (I) (we) last saw the deceased alive on 9/2 , 19 67 , and that death occurred at 8:47 M, from causes and on the date stated above.			
22a. SIGNATURE Russell & Bufalino M.D.		22b. DATE SIGNED Sept 5 1967	
22c. PHYSICIAN'S NAME (Type) Russell, Bufalino, M.D.		22d. ADDRESS 1429 University Blvd., West, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/7/67	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Pk., Landover Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Johnson Jenkins		25a. REC'D BY REGISTRAR SEP 11 1967	
ADDRESS 4801 Ga Ave N.W.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

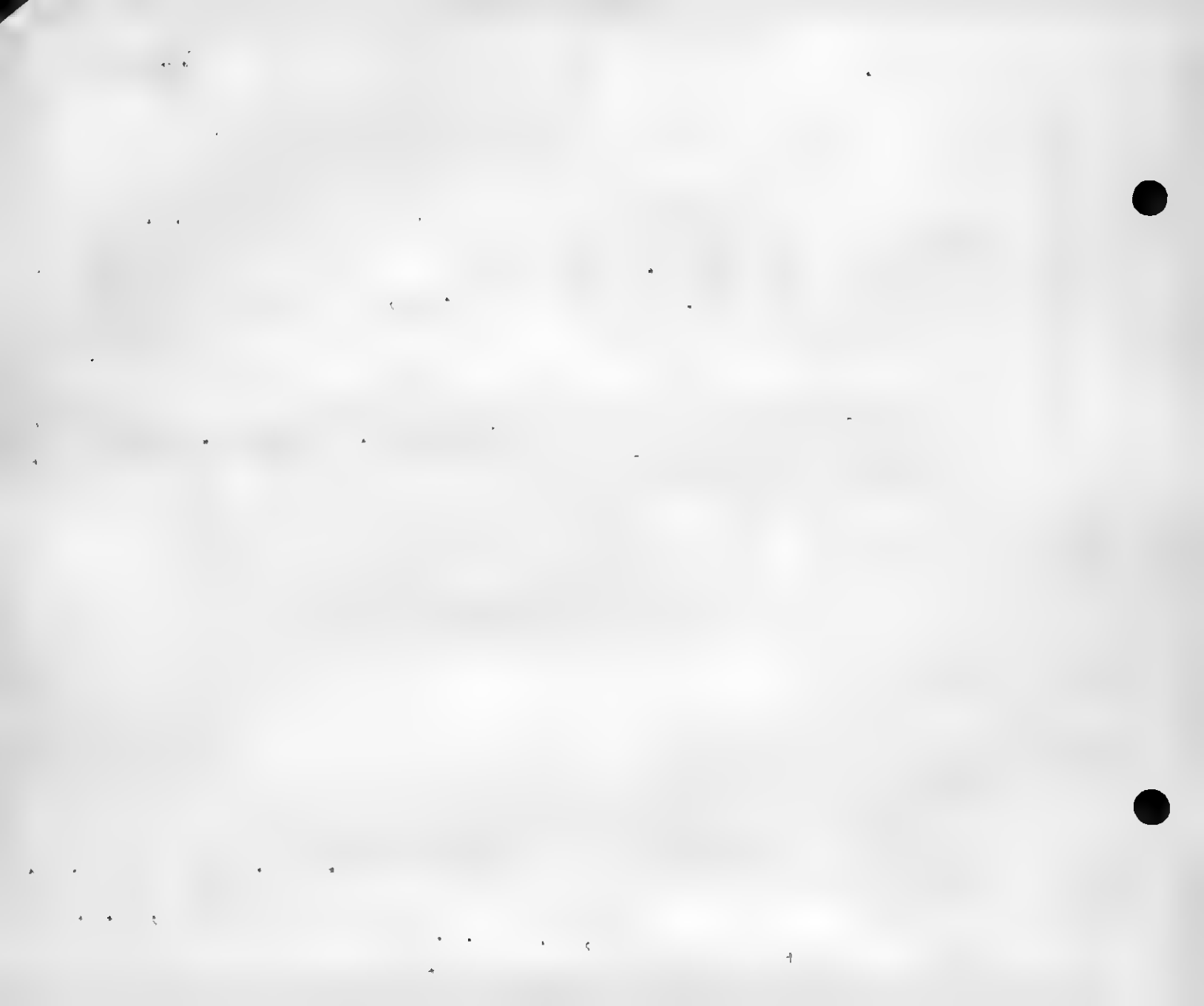
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12608

CERTIFICATE OF DEATH

12617

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Hospital & Sanitarium</u>		d. STREET ADDRESS <u>1414 Nicholson Street N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas A. (XXXX) Griffin</u>		4. DATE OF DEATH Month Day Year <u>September 1 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1877</u> <u>XXXXXX</u>
9. AGE (In years last birthday) <u>90</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Department employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mulkerin</u> <u>XXXXXX</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>578-36-2863A</u>	
17. INFORMANT <u>William R. Griffin</u>		Address <u>Silver Spring Md.</u> <u>11405 Nairn Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>old age</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>massive bronchitis + emphysema</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> , 19 <u>—</u> , to <u>Sept 1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 1</u> , 19 <u>67</u> , and that death occurred at <u>2:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Philip Bloemsma</u>		22b. DATE SIGNED <u>Sept 1, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip Bloemsma</u>		22d. ADDRESS <u>7701 Conn. Ave. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, <u>Burial</u>		23b. DATE THEREOF <u>9/4/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

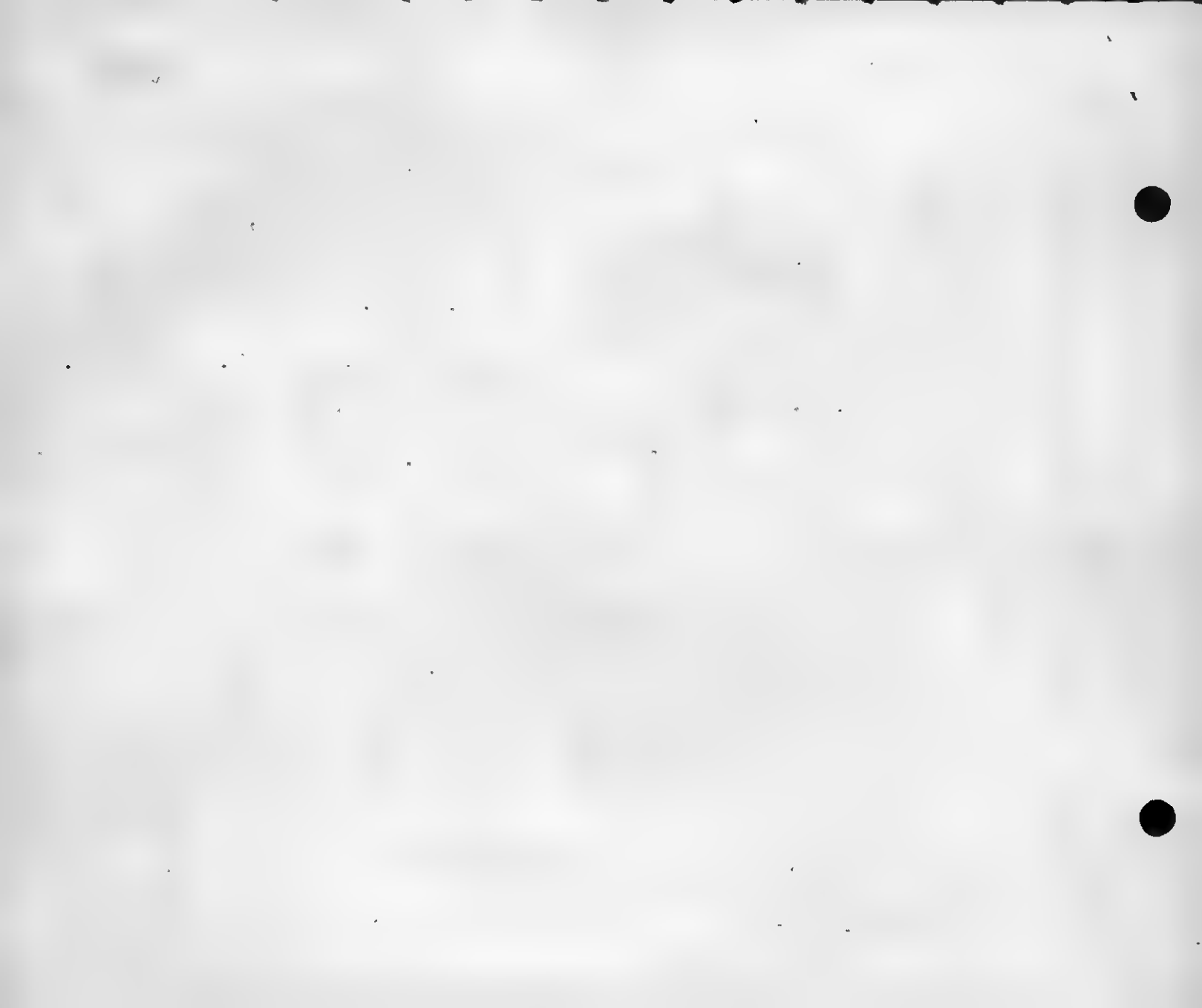


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12609					12618				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Montgomery					a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington				
c. LENGTH OF STAY IN 1b years					d. STREET ADDRESS 9900 Old Spring Road				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9900 Old Spring Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Carolyn Middle Giles Last Groff					Month September Day 26 Year 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 2, 1901		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME James L. Giles					14. MOTHER'S MAIDEN NAME Nettie B. Nicholson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-58-4480		17. INFORMANT Husband		Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 451X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Dissecting Aortic Aneurysm (c) } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 month 20 months				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb 13, 1966 , to Sept 26, 1967 , that (I) (we) last saw the deceased alive on Sept 25, 1967 , and that death occurred at 7⁰⁰ AM , from the causes and on the date stated above.									
22a. SIGNATURE Robert B. Havell					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept 26, 1967		
22c. PHYSICIAN'S NAME (Type) Robert B. Havell MD					22d. ADDRESS 5516 Nebraska Ave - DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-29-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town or county) (State) Suitland Maryland			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR OCT 2 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12619

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits write RURA and give nearest town) <u>Shiloh</u>		c. CITY OR TOWN (If outside corporate limits write RURA and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY in lb <u>72 hrs</u>		d. STREET ADDRESS <u>1115 Wisconsin Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Trusting Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rose T. Grundstein</u>		4. DATE OF DEATH <u>Sept 9 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lithuania</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ben Kalinsky</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Pieloff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-54-5090</u>	
17. INFORMANT <u>Mrs Anne Grundstein</u>		Address <u>4401 14th Avenue Wash. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Chronic Myocardial Disease</u> DUE TO (c) <u>Systolic Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>		22. DATE SIGNED <u>7-9-67</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		Address <u>1919 Summit Rd. S.W. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-11-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CHESEBROOKS CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>CLEVELAND OHIO</u>	
24. FUNERAL DIRECTOR <u>Goodbye Funeral Home</u>		ADDRESS <u>4217 9th St. N.W.</u>	
25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12611

CERTIFICATE OF DEATH

12620

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN lb <u>3 days</u>		d. STREET ADDRESS <u>5610 Southwell St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harvey L. Haight</u>		4. DATE OF DEATH <u>Sept 3, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/90</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry S. Haight</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe Sneed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-9733A</u>	
17. INFORMANT <u>Doris O. Haight</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary arteriosclerosis with thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, pyelonephritis, acute and chronic, Carcinoma U. Blad.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>67</u> , to <u>9-3-</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9-3-</u> 19 <u>67</u> , and that death occurred at <u>2:10 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ronald W. Barr</u>		22b. DATE SIGNED <u>9-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RONALD W BARR</u>		22d. ADDRESS <u>10410 Old Georgetown Rd. Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12612

CERTIFICATE OF DEATH

12621

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Wash. D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 9 Mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wash. D.C.		d. STREET ADDRESS 2500 Q St. N.W.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea Woodland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sara Middle S. Last Hamner		4. DATE OF DEATH Month SEPT Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1886
9. AGE (In years last birthday) 80		10. IF UNDER 1 Year Months 19 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas A. Sale		14. MOTHER'S MAIDEN NAME Ann Thrower	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Longstreet		Address 2500 Q St. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO (b) Cerebral Thrombosis DUE TO (c) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH Stat. unk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-9-1966 to 9-19-1967 that (II) (we) last saw the deceased alive on 9-9-1967 and that death occurred at 8:55 AM from causes and on the date stated above			
22a. SIGNATURE Robert S. Poole		22b. DATE SIGNED 9-19-67	
22c. PHYSICIAN'S NAME (Type) ROBERT S. POOLE		22d. ADDRESS 4501 CONN AVE.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-1967	
23c. NAME OF CEMETERY OR CREMATORY Old Odd Fellows		23d. LOCATION (City or Town) (County) (State) Aberdeen Miss.	
24. FUNERAL DIRECTOR Jos. Gawler		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Jos. Gawler		25c. ADDRESS 8s Sons 5130 Wisc. Ave. N.W.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12622

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>J. Patricia Hannan</u>		4 DATE OF DEATH <u>Sept. 16 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Mar. 17, 1902</u> 9 AGE (In years last birthday) <u>65 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>DANIEL SULLIVAN</u>		14. MOTHER'S MAIDEN NAME <u>AGNES SHEEHY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO.	
17. INFORMANT <u>NURSING HOME RECORDS.</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>X Heart</u> DUE TO <u>Cerebral Vascular Deceler</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Cerebral Arterio Sclerosis</u> (b) <u>Cerebral Arterio Sclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/11/67</u> to <u>9/16 1967</u> , that (I) (we) last saw the deceased alive on <u>9/16/67</u> , and that death occurred on <u>9/16</u> M, from causes and on the date stated above			
22a SIGNATURE <u>William T. Gray Sr. M.D.</u>		22b DATE SIGNED <u>9/16/67</u>	
22c PHYSICIAN'S NAME (Type) <u>William T. Gray Sr. M.D.</u>		22d ADDRESS <u>7005 Maple A Chevy Chase Md</u>	
23a BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>9/20/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	23d LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>
24 FUNERAL DIRECTOR <u>HANLON FUNERAL HOME-</u>		25a REC'D BY REGISTRAR <u>SEP 25 1967</u>	
ADDRESS <u>WASH. D.C.</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12614

12623

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>P.O.A.</u>		d. STREET ADDRESS <u>1136 University Blvd. E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>DAVID R. HARKER</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1967</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 26 1906</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Trenton, New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David R. Harker</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>720-14-6370</u>	
17. INFORMANT <u>Mrs. Jean L. Pannoni</u> Address <u>Step. daughter 1036 Univ. Blvd. E.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 mos</u> <u>24 mos</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>adenocarcinoma right kidney - 6.5 mos.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this deceased) attended the deceased from <u>7/23</u> , 19 <u>62</u> , to <u>9/20</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/17</u> , 19 <u>67</u> , and that death occurred at <u>6:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Harry N. Carlton</u>		22b. DATE SIGNED <u>9/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u>		22d. ADDRESS <u>8811 Colesville Rd., S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Maryland</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> 8434 <u>Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
<u>Warner E. Humphrey, Inc.</u> Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

12615

Item #7 Film #G392 9/23/67

CERTIFICATE OF DEATH

12624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6820 - The Georgetown Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Thornton J. Halperman</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/94</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>5. Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Robert Halperman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Newton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Patricia Kelsch</u>		Address <u>Bethesda</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>pulmonary infarction, multiple, bilateral</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atrial thrombosis</u> DUE TO (c) <u>arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> <u>2 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>April, 1966</u> to <u>Sept</u> , 1967, that (I) (we) last saw the deceased alive on <u>Sept 14, 1967</u> , and that death occurred at <u>5:00</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/15/67</u>
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER, M.D.</u>		22d. ADDRESS <u>8218 Wise Av. Beth, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/18/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	23d. LOCATION (City or town) (County) (State) <u>SILVER SPRING - MONT. - MD.</u>
24. FUNERAL DIRECTOR <u>W. W. Chambers</u>		25a. REC'D BY REG. STR. <u>SEP 19 1967</u>	
ADDRESS <u>Silver Spring Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12616

CERTIFICATE OF DEATH

12625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS South 3016/Buchanan Street	
3 NAME OF DECEASED (Type or print) First Brian Middle C. Last HART		4. DATE OF DEATH Month September Day 28 Year 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1967
9 AGE (in years last birthday) yrs		IF UNDER 1 YEAR Months 1 Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	11. BIRTHPLACE (County & State, or foreign country) Quantico, Virginia
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Patrick T. Hart	
14. MOTHER'S MAIDEN NAME Frances Rams		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A	
16. SOCIAL SECURITY NO. N/A		17. INFORMANT Buchanan St. Address Arlington, Va. LCDR Patrick T. Hart, USN, 3016 South	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio Respiratory Distress. 711.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Hemorrhage DUE TO (c) Bilateral Subarachnoid Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from Sept. 27, 1967 , to Sept. 28, 1967 , that (he) (we) last saw the deceased alive on Sept. 28, 1967 , and that death occurred at 2300 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 1967 28 September	
22c. PHYSICIAN'S NAME (Type) T. X. IOEB, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR <i>[Signature]</i> Falls Church Funeral Home 1102 West Broad St., Falls Church, Va.		25. RECEIVED BY REGISTRAR OCT 3 1967 DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12617		12626	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>SOUTH CAROLINA</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUFUS</u> Middle <u>D.L.</u> Last <u>HARVEY</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 12, 1901</u>
9. AGE (In years lost birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Machinery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>249-03-7448</u>	
17. INFORMANT <u>MRS. ARLENE REGISTER</u>		Address <u>2923 UNIVERSITY BLVD KENSINGTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis with Rt. Hemiplegia</u> DUE TO (b) <u>Cerebral Atherosclerosis</u> DUE TO (c) <u>2 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>8 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>auricular Fibillation and Rt. Bundle Branch Block</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUG. 1</u> , 19 <u>67</u> , to <u>SEPT. 18</u> , 19 <u>67</u> , that (II) (we) lost the deceased alive on <u>SEPT. 18</u> 19 <u>67</u> , and that death occurred at <u>3:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>James A. Roberts</u>		22b. DATE SIGNED <u>SEPT. 18, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>		22d. ADDRESS <u>8907 GEORGIA AVE. SILVER SPRING, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>Sept. 21, 1967</u>	<u>Riverview Memorial Park</u>	<u>North Charleston, S. C.</u>
24. FUNERAL DIRECTOR <u>John B. Thomas & Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Humphrey, Inc.</u>	
25b. REGISTRAR'S SIGNATURE <u>SEP 21 1967</u>		25c. REGISTRAR'S SIGNATURE <u>SEP 21 1967</u>	

12618

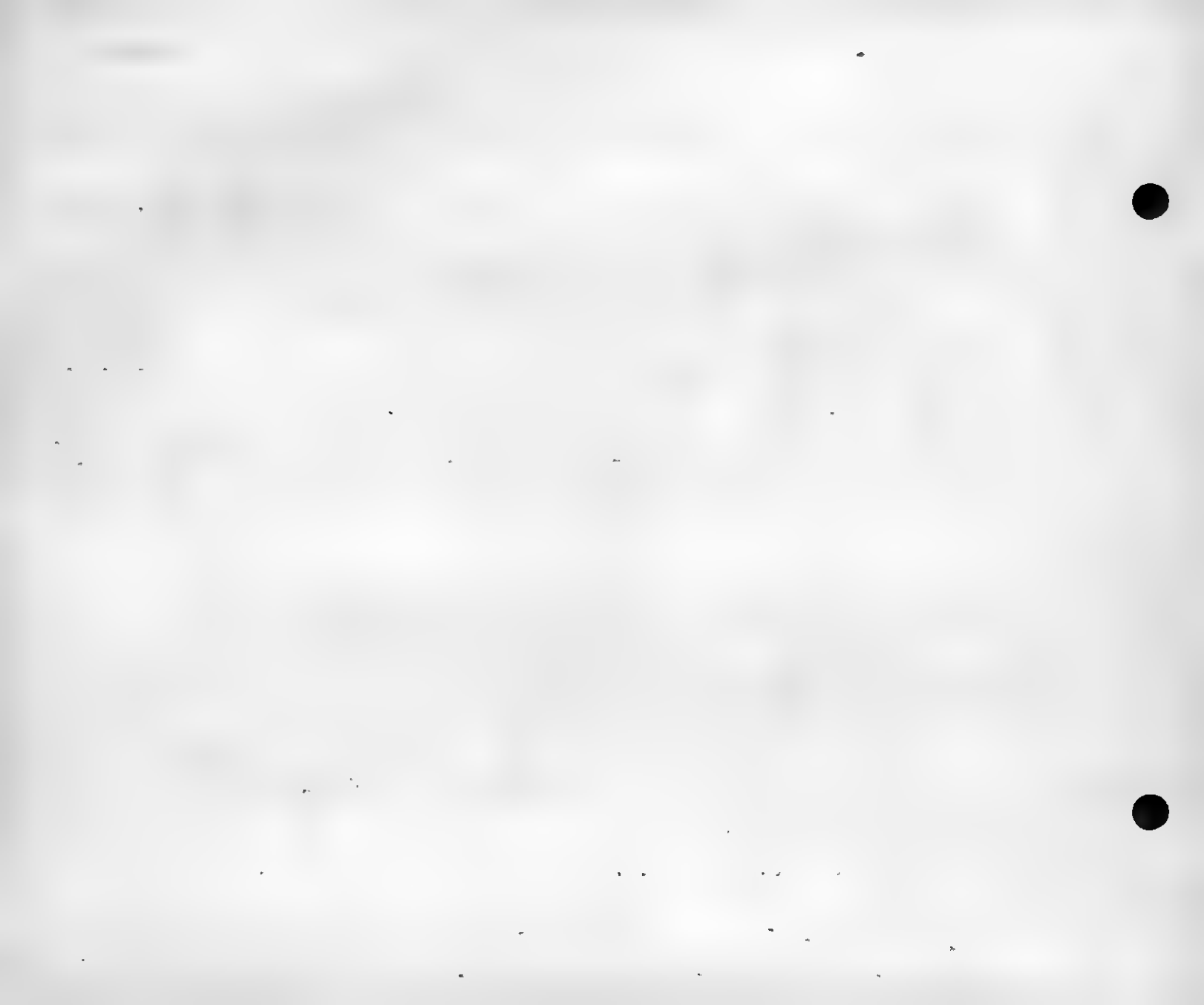
CERTIFICATE OF DEATH

12627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>10403 Brunswick Ave. Silver Spring, Md.</u>	
3 NAME OF DECEASED (Type or print) <u>Martha Leta Hasselbring</u>		4 DATE OF DEATH <u>9-5-1967</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/25/1900</u>
9 AGE (In years last birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Monticello, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles D. Gardner</u>		14. MOTHER'S MAIDEN NAME <u>Lida M. Straight</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>812-22-2554</u>	
17. INFORMANT <u>Prod C. Hasselbring</u>		Address <u>10403 Brunswick Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO (b) <u>Pneumatoid Arthritis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASHD</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/15/65</u> to <u>9/5/67</u> , that (I) (we) last saw the deceased alive on <u>9/5/67</u> , and that death occurred at <u>2:25 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>John J. Curry</u>		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John J. Curry, M.D.</u>		22d. ADDRESS <u>10620 Georgia Ave., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Trans-Sun Sep. 10, 1967</u>		<u>River View Cemetery Monticello, Indiana</u>	<u>Monticello, Indiana</u>
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DATE <u>SEP 8 1967</u>		<u>Charles J. ...</u>	



12613

CERTIFICATE OF DEATH

12628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Omney c. LENGTH OF STAY IN 1b 1 hr. 42 min.		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4324 Kenbar Bethesda Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital		d. STREET ADDRESS 4324 Kenbarway Dr.	
3. NAME OF DECEASED (Type or print) Baby Boy		4. DATE OF DEATH Month 9 Day 17 Year 1967	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 0
11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy B. Hawkins		14. MOTHER'S MAIDEN NAME Linda L. Whetzel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Leroy B. Hawkins, Item 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-17, 1967 to 9-17, 1967 , that (I) (we) last saw the deceased alive on 9-17, 1967 , and that death occurred at 4:45 AM , from causes and on the date stated above.			
22a. SIGNATURE L. S. Batman		22b. DATE SIGNED 9/17/67	
22c. PHYSICIAN'S NAME (Type) L. S. Batman, M.D.		22d. ADDRESS Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY Damascus Meth.	23d. LOCATION (City or Town) (County) (State) Damascus, Md.
24. FUNERAL DIRECTOR Olin L. Molesworth, Damascus, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 1967	
		25b. REGISTRAR'S SIGNATURE Judge	

1

2

12520

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12629

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY MONTGOMERY Co. MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c LENGTH OF STAY IN 1b 16 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RAUDOLPH HILLS NURSING HOME		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BENJAMIN C. HAWKINS		4 DATE OF DEATH Month Sept. Day 16 Year 1967	
5 SEX MALE	6 COLOR OR RACE C	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-12-1880
9a AGE (In years lost birthday) 87 yrs		9b IF UNDER 1 YEAR Months Days Hours Mins.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JAMES HAWKINS		14. MOTHER'S MAIDEN NAME LIZA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 219-12-47664	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 4 mos	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/1/67 , 19__, to 9/16/67 , 19__, that (I) (we) last saw the deceased alive on 9/15 , 19 67 , and that death occurred at 1 P M, from causes and on the date stated above.			
22a SIGNATURE Patricia C. Jamerson M.D.		22b DATE SIGNED 9/16/67	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS 11718 Georgia Silver Spring Md	
23a BURIAL (CREMATION, REMOVAL (Specify))	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	9/20/67	Ash Memorial	Sandy Spring Md
24. FUNERAL DIRECTOR George R. Snowden		25a REC'D BY REGISTRAR SEP 21 1967	
ADDRESS Rockville Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12630

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 12 days		2 USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 5502 40th Avenue	
3 NAME OF DECEASED (Type or print) Kyle		First G		Last Hawthorne	
4 DATE OF DEATH September 18 1967		Month 18		Day 19	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8/3/04	9. AGE (In years of birthday) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Town & Casual Shoes		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Noah B Hawthorne		14. MOTHER'S MAIDEN NAME Nettie Grant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215 07 2098		17. INFORMANT Marguerite Hawthorne	
18. ADDRESS Hyattsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPTICEMIA, GRAM NEGATIVE DUE TO (b) PERITONITIS, GENERALIZED DUE TO (c) PERFORATED SMALL INTESTINE INTERVAL BETWEEN ONSET AND DEATH 12 DAYS 12 DAYS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, A.S.H.D., OBESITY 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9-7 , 19 67 , to 9-18 , 19 67 that (I) (we) lost the deceased alive on 9-18 , 19 67 , and that death occurred on 9-18 PM, from causes and on the date stated above.					
22a. SIGNATURE Leonard L. Deitz		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/19/67	
22c. PHYSICIAN'S NAME (Type) Leonard Deitz, M.D.		22d. ADDRESS 1111 Spring Street, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md.					
24. FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE					

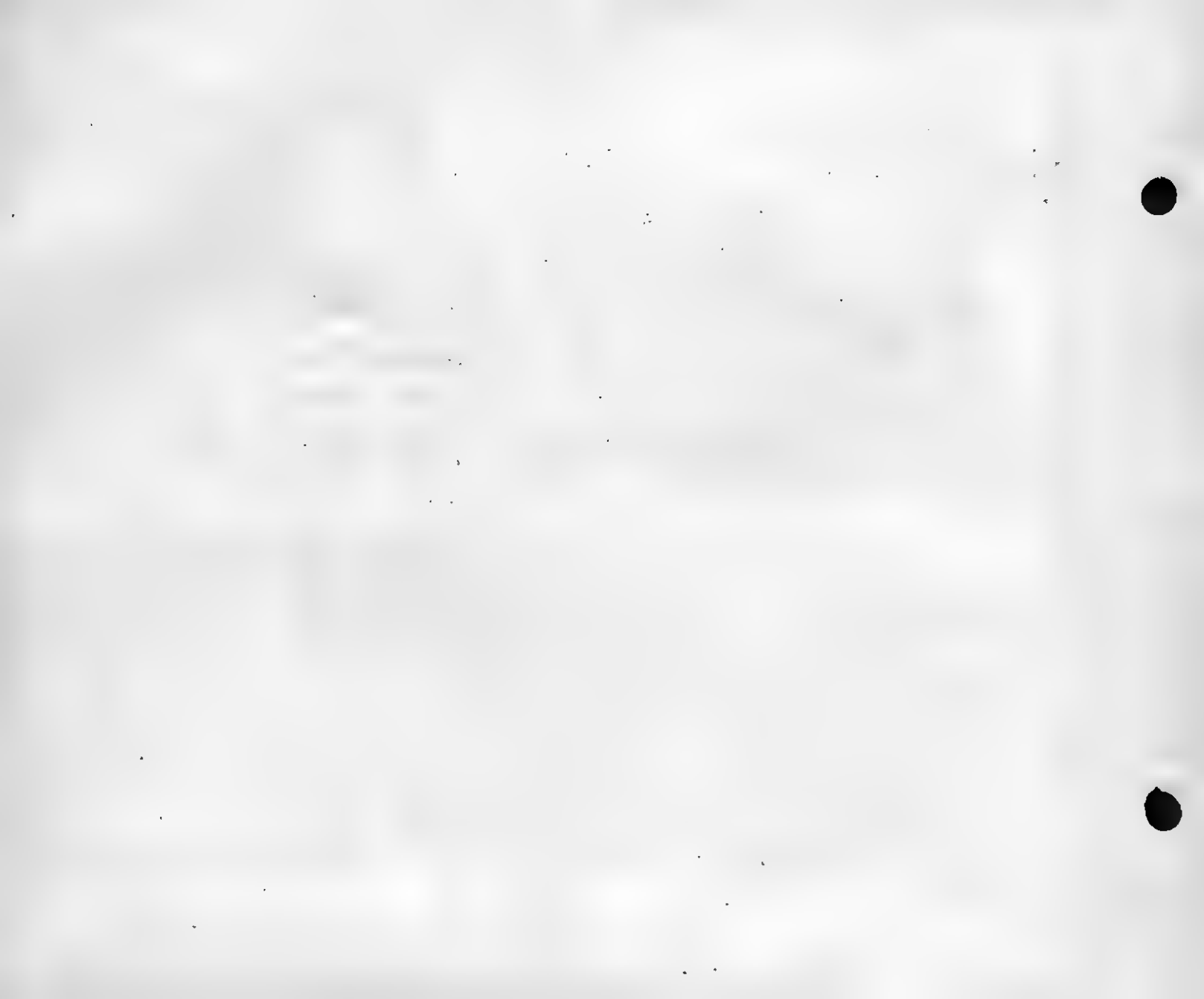
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12622 CERTIFICATE OF DEATH 12631

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Capoma Park</u> c. LENGTH OF STAY IN 1b <u>5 1/2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Capoma Park</u> d. STREET ADDRESS <u>6720 Conway Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>HAYES</u>		4. DATE OF DEATH <u>September 21, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1917</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months <u>16</u> Days <u>16</u> Hours <u>16</u> Min. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Maritime Exam</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hayes</u>		14. MOTHER'S MAIDEN NAME <u>Not Available</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>U.S. Army</u>		16. SOCIAL SECURITY NO. <u>715-03-5709</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u> 4201 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last, DUE TO (b) <u>Coronary Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec, 1958</u> , to <u>9-21, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-20, 1967</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Gilbert B. Cusher</u>		22b. DATE SIGNED <u>9-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>GILBERT B. CUSHER</u>		22d. ADDRESS <u>11161 New Hamp. Ave Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Sept 23-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest of Annapolis Shores Inc. Md</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12632											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14 Park Ave.</u>				d. STREET ADDRESS <u>14 Park Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Elizabeth</u> Last <u>Heim</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>28th</u> Year <u>1967</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6th 1884</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>!!!</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>					
13. FATHER'S NAME <u>Edward Heim</u>				14. MOTHER'S MAIDEN NAME <u>Malinda Kemp</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Leila G. Briggs. Gaithersburg, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Broncho-pneumonia</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9-25-</u> , 19 <u>67</u> , to <u>9-28-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-28-</u> , 19 <u>67</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>F.J. Broschant</u>				M.D. <u> </u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-29-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.J. Broschant</u>				22d. ADDRESS <u>1111 Union St Gaithersburg Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10 Oct 1st 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		23d. LOCATION (City, town or county) <u>Gaithersburg, Md.</u>		(State) <u> </u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Garther</u>				ADDRESS <u>Gaithersburg, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	
				DATE <u>OCT 3 1967</u>							



12624

CERTIFICATE OF DEATH

12633

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 151</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>9039 Sligo Creek Pkwy</u>	
3 NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>A.</u> Last <u>Heller</u>		4. DATE OF DEATH <u>September 1</u> 19 <u>67</u> Month Day Year	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-18-12</u> 54 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager, Shoe Dept.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>	
13 FATHER'S NAME <u>HARRY HELLER</u>		14. MOTHER'S MAIDEN NAME <u>SADIE</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Rosalind Heller Creek Pkwy. S.S. Md</u>		Address <u>9039 Sligo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASHDE acute myocardial infarction - recurrent</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>infarction - recurrent</u> (c) <u>infarction - recurrent</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Diabetes mellitus 2) Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> , 19 <u>66</u> , to <u>9-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-1</u> , 19 <u>67</u> , and that death occurred at <u>1:31 AM</u> , from causes and on the date stated above.		21f (City or town) (County) (State)	
22a SIGNATURE <u>Robert S. Waldman</u> M.D.		22b DATE SIGNED <u>9-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert S. Waldman, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/3/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Gar.</u>	23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Va.</u>
24 FUNERAL DIRECTOR <u>Bernard Danzansky & Sons St. NW., Wash. DC</u>		25a REC'D BY REGISTRAR <u>SEP 5 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12625

CERTIFICATE OF DEATH

12634

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Na N.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Na Midway Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital Bethesda, Maryland		d. STREET ADDRESS Na 315 Butler Ave e. IS RESIDENCE ON ANOTHER PREMISE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) David Lee HELTON Jr.		4 DATE OF DEATH Month 9 Day 4 Year 1967	
5 SEX Male	6. COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Na DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 15 AUG 1967
9 AGE (In years last birthday) 00 20		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Na	
10b KIND OF BUSINESS OR INDUSTRY Na		11 BIRTHPLACE (County & State, or foreign country) Camp Lejeune, N.C.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME David Lee Helton Sr.	
14 MOTHER'S MAIDEN NAME Phyllis Smith		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Na Na	
16 SOCIAL SECURITY NO Na		17 INFORMANT David Lee Helton Sr. Midway Park, N.C.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1340 Congenital Heart Disease DUE TO (b) Tetralogy Of Fallot DUE TO (c) Na			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Na	
20c. TIME OF INJURY Month, Day, Year Hour a.m. Na 19 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Na		20f (City or town) (County) (State) Na	
21. I certify that (I) (this hospital) attended the deceased from 2 Sept , 19 67 , to 4 Sept , 19 67 , that (I) (we) lost saw the deceased alive on 4 Sept , 19 67 , and that death occurred on 1240AM , from causes and on the date stated above.			
22a. SIGNATURE R.A. Humphrey		22b. DATE SIGNED 4 SEPT 67	
22c. PHYSICIAN'S NAME (Type) R.A. Humphrey A.E. TOMPKINS		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a BURIAL, CREMAT. OR REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 7, 1967	
23c NAME OF CEMETERY OR CREMATORY Earlham Cemetery		23d LOCATION (City or Town) (County) (State) Richmond, Indiana	
24 FUNERAL DIRECTOR R.A. Humphrey (For Richmond, Indiana)		25a REC'D BY REGISTRAR SEP 8 1967	
		25b REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

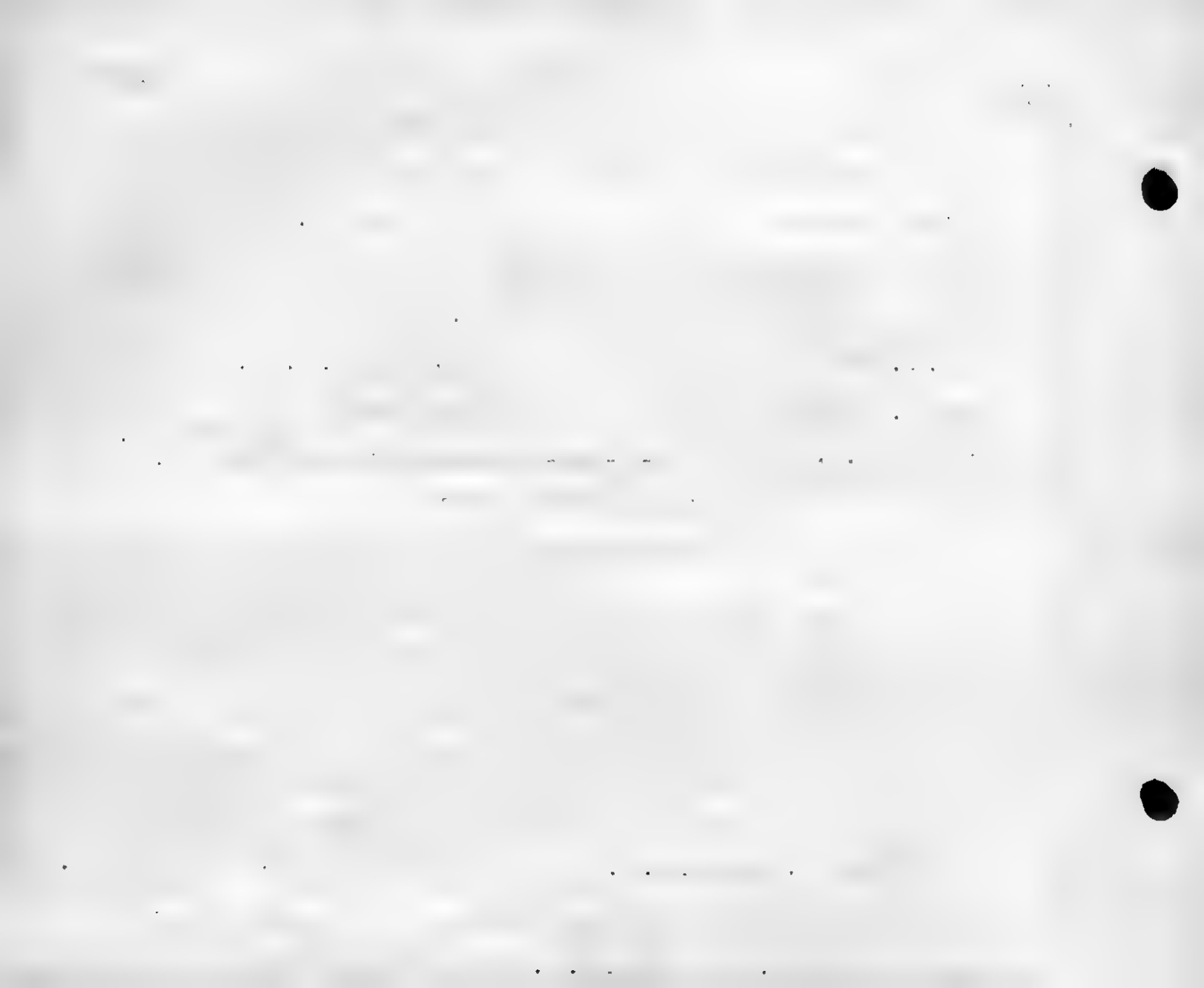
12626

12635

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 42 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton d. STREET ADDRESS 2610 Weller Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Montgomery Earle HIGGINS		4. DATE OF DEATH Month September Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29 1879
9. AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Armed Forces	
11. BIRTHPLACE (County & State, or foreign country) Sir Johns Run, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. HIGGINS		14. MOTHER'S MAIDEN NAME Alice Cross	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.I & II		16. SOCIAL SECURITY NO 579-46-9922-A	
17. INFORMANT Montgomery Higgins		2610 Weller Rd.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 Aug 67 , 19 67 , to 28 Sep , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 Sept , 19 67 , and that death occurred at 12:59P from causes and on the date stated above.			
22a. SIGNATURE Lawrence W. Raymond		22b. DATES SIGNED	
22c. PHYSICIAN'S NAME (Type) Lawrence W. Raymond, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/3/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25a. REC'D BY REGISTRAR OCT 3 1967	
5130 Wisconsin Ave., Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12627

CERTIFICATE OF DEATH

12636

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN TB 6 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 11200 Lockwood Dr., Apt. 608	
3 NAME OF DECEASED (Type or print) First Lorna Middle Mae Last Hill		4. DATE OF DEATH Month 9 Day 16 Year 19 67	
5 SEX Female	6 COLOR OR RACE Caus.	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 16, 1891
9 AGE (In years last birthday) yrs 76		10 IF UNDER 1 YEAR Months 8 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Bearaboo, Wisconsin		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Young		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-12-1614	
17. INFORMANT Mr. Lawrence Hill		Address 11200 Lockwood Drive Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 1657 IMMEDIATE CAUSE (a) Carcinomatosis - generalized DUE TO (b) Carcinoma parotid Glands DUE TO (c) 8 years		INTERVAL BETWEEN ONSET AND DEATH 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to 9/16 , 19 67 that (I) (we) last saw the deceased alive on 9/15 , 19 67 , and that death occurred at 6:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Sally N. Carlton		22b. DATE SIGNED 9/16/67	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON, MD		22d. ADDRESS 8811 Colosville Rd, S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 1967	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR J. B. Thomas & Son		25a. REC'D BY REGISTRAR SEP 21 1967	
Address 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12628

CERTIFICATE OF DEATH

12637

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Break Grove Foundation (SHARON)</u>		d. STREET ADDRESS <u>16725 44th Ave -</u>	
4 NAME OF DECEASED (Type or print) <u>Moultrie</u>		4 DATE OF DEATH <u>Sept 25 1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/4/1883</u>
9 AGE (In years last birthday) <u>84</u>		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Augusta, Ga.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augustus</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Woolfork</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>213-8-2618</u>	
17 INFORMANT <u>Jennie Hitt, Wife</u>		Address <u>Same as Above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CVA</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (b) <u>Atherosclerosis</u> (c) <u>Atherosclerosis</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>6-2</u> , 19 <u>67</u> to <u>9-25</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>9-24 1967</u> , and that death occurred at <u>7:45 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Burton A. Johnson</u>		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Burton A. Johnson</u>		22d. ADDRESS <u>11358 Cherry Hill Rd, Beltsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Magnolia Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Augusta Georgia</u>
24. FUNERAL DIRECTOR <u>GASCH'S</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	
HYATTSVILLE, MARYLAND		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12630

CERTIFICATE OF DEATH

12639

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE NEW YORK b. COUNTY NEW YORK			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) AURORA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First TEMPLE Middle RICE Last HOLLCROFT				4 DATE OF DEATH Month SEPT Day 1 Year 1967			
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-8-89	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HISTORIAN		10b. KIND OF BUSINESS OR INDUSTRY PROFESSOR		11 BIRTHPLACE (County & State, or foreign country) ALTON, IND.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JOHN TIPTON HOLLCROFT				14 MOTHER'S MAIDEN NAME CLARA BECKIN PAUGH			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16 SOCIAL SECURITY NO. W. W. I 111-24-8117A		17. INFORMANT COPIED FROM CHART AT NURSING HOME Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 4200 ACUTE BRONCHO PNEUMONIA DUE TO (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH DAYS DAYS YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 27, 1967 to SEPT. 1, 1967 , that (I) (we) last saw the deceased alive on SEPT. 1, 1967 , and that death occurred at 9P M, from causes and on the date stated above.							
22a. SIGNATURE Albert H. Grollman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/1/67	
22c. PHYSICIAN'S NAME (Type) ALBERT H. GROLLMAN				22d. ADDRESS 1106 SILVER SPRING ST. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-67		23c. NAME OF CEMETERY OR CREMATORY OAK Glen		23d. LOCATION (City or Town) (County) (State) AURORA, N.Y.	
24. FUNERAL DIRECTOR Joseph Fowler Jones - Washington D.C.				25a. REC'D BY REGISTRAR SEP 7 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

12629

CERTIFICATE OF DEATH

12638

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1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN It <u>20 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium Hospital</u>		d. STREET ADDRESS <u>9417 Colesville Rd</u>	
3. NAME OF DECEASED (Type or print) <u>John Joseph Hook</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-97</u>
9. AGE (In years lost birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Hook</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Ward</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-01-1135</u>	
17. INFORMANT <u>Emily B. Hook</u> Address <u>9417 Colesville Rd. S.S. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Carcinoma lung</u> DUE TO (c) <u>Unknown</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 5, 1967</u> , to <u>SEPT 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>24 SEPT 1967</u> and that death occurred at <u>2:47 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinman Jr.</u> M.D.		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinman Jr.</u>		22d. ADDRESS <u>831 University Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12631

12640

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>32 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		13	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014</u> <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>39 Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Terri</u> Middle <u>Sue</u> Last <u>Honeycutt</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 November 1963</u>		9. AGE (in years last birthday) <u>3</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert C. Sonifrank</u>				14. MOTHER'S MAIDEN NAME <u>Gladys Honeycutt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction with perforation and</u> <u>1001</u> DUE TO <u>Intra-abdominal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Lymphosarcoma</u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia; Thrombophlebitis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from <u>14 August, 1967</u> , to <u>15 Sept., 1967</u> , that (X) (we) last saw the deceased alive on <u>15 September 19 67</u> , and that death occurred at <u>8:35</u> M. from causes on and on the date stated above.							
22a. SIGNATURE <u>Arthur R. Ugel</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>16 Sept. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur R. Ugel, MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		23b. DATE THEREOF <u>9-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cook's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Cook's Cemetery</u>	
24. FUNERAL DIRECTOR <u>354 22nd St. NW Wash D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

12632

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>3 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		e. STREET ADDRESS <u>3714 Cardliff Court.</u>	
3 NAME OF DECEASED (Type or print) <u>Kate Elgin Howard</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>August 26, 1884</u> AGE (in years last birthday) <u>83</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11 BIRTHPLACE (State or foreign country) <u>Alabama</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>William M. Elgin</u>		14 MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>- - -</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17 INFORMANT <u>A. Allen Howard - Husband</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis -</u> DUE TO (b) <u>Arterio Sclerosis - Generalized -</u> DUE TO (c) <u>- - -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>3 days -</u> <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Bell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John S. Bell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/24/67</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL <u>Removal</u>	23b. DATE THEREOF <u>9-26-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Fairfax, Va.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
5130 Wisc. Ave. N.W. Wash., D.C.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12633

12642

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN ID 2 mths.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 12921 Old Columbia Pike				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington,			
f. STREET ADDRESS 1805 Monroe St., N. E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GUY		First LESLIE		Last HOYME		4. DATE OF DEATH Month Sept. Day 4 Year 1967	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13 1873	
9. AGE (in years last birthday) 93 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect				10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Culpeper, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Wm. St. Hoyme				14. MOTHER'S MAIDEN NAME Charlotte E. Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Dr. Lucile E. St. Hoyme				Address 1805 Monroe N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism. 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Myocardial Disease DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 2 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. DATE SIGNED 9-5-67							
ACTUAL SIGNATURE John S. Rogers				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN S. ROGERS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR Arthur Walters 754 Canal St. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR SEP 7 1967			
25b. REGISTRAR'S SIGNATURE							



12634

CERTIFICATE OF DEATH

12643

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 909 Lewis Ave.		d. STREET ADDRESS 909 Lewis Ave.	
3 NAME OF DECEASED (Type or print) First HINDA Middle V. Last HUDSON		4 DATE OF DEATH Month September Day 25 , Year 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 21, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) 52 yrs
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Alfred L. Fraley		14 MOTHER'S MAIDEN NAME Dorothy Kinney	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 577-48-5066	
17 INFORMANT Maynard Hudson - husband - same item #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Metastatic adenocarcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Adenocarcinoma of breast DUE TO (c) 170X			INTERVAL BETWEEN ONSET AND DEATH 2 years 8 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			9 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1953 , 19____, to Sept. 25, 1967 , that (I) (we) last saw the deceased alive on Sept. 25, 1967 , and that death occurred at 6:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>William G. Hall</i> M.D.		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) William G. Hall		22d. ADDRESS 815 W. Montgomery Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/28/67	23c. NAME OF CEMETERY OR CREMATORY St. Mary's	23d. LOCATION (City or town) (County) (State) Rockville Montg. Md.
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 29 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

12635

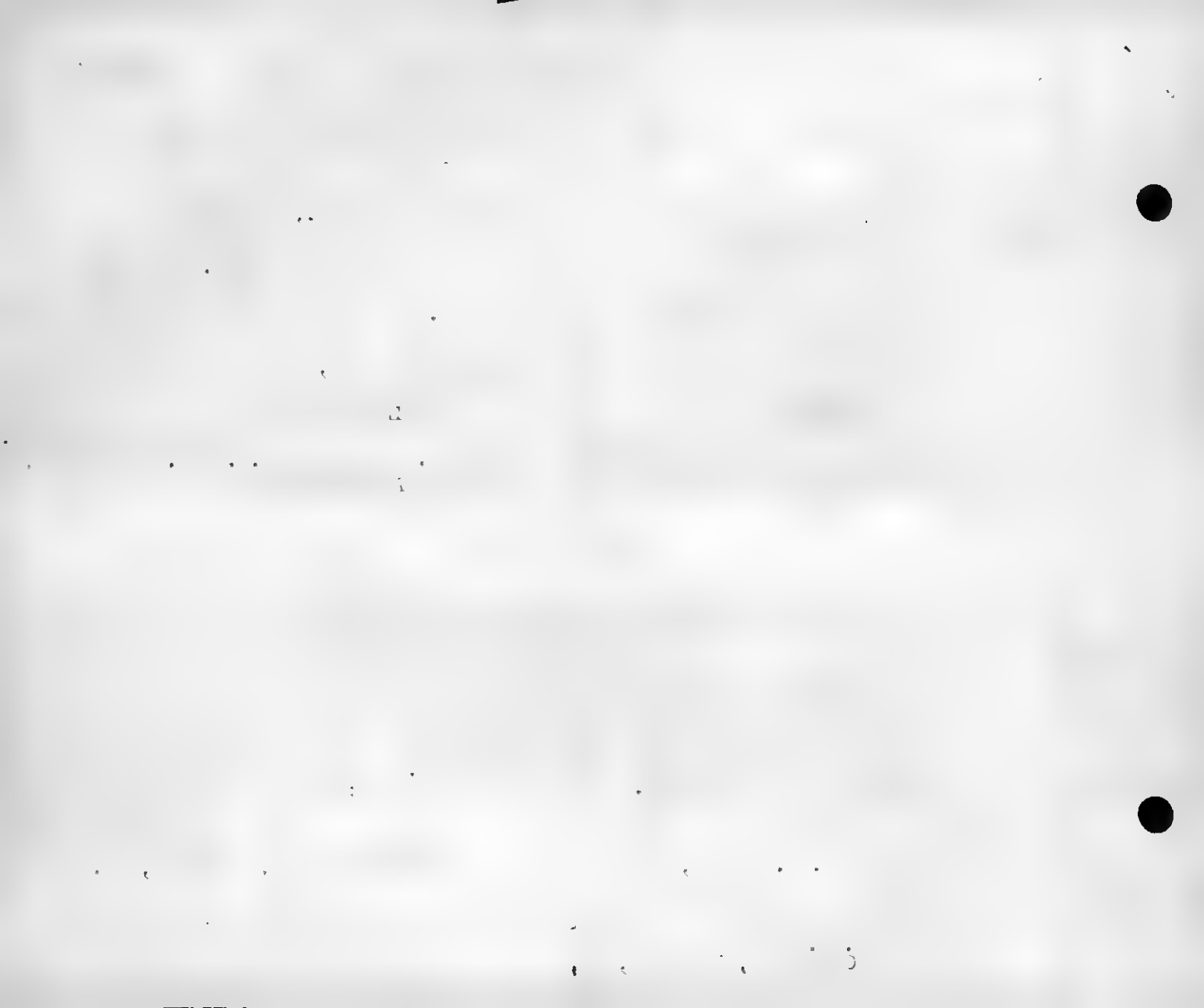
CERTIFICATE OF DEATH

12644

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VIENNA	
c. LENGTH OF STAY IN 1b 24 DAYS		d. STREET ADDRESS 126 PATRICK ST., SOUTHEAST	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US NAVAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle A Last HULL		4. DATE OF DEATH Month SEPT. Day 16 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 FE. 1929
9. AGE (In years last birthday) 38 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) SULLIVAN CITY, TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABNER BREWER		14. MOTHER'S MAIDEN NAME ELIZABETH PATRICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 414347495	
17. INFORMANT ROBERT S. HULL		Address 126 PATRICK ST. S.E. APT. 260 VIENNA, VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ESOPHOGEAL VARICES WITH GASTROINTESTINAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRRHOSIS OF LIVER DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 23 AUG. 1967 , to 16 SEPT. 1967 , that (we) last saw the deceased alive on 16 SEPT. 1967 , and that death occurred at 4:20AM , from causes on the date stated above.			
22a. SIGNATURE C. S. CRUMMY, MD		22b. DATE SIGNED 16 SEPT 1967	
22c. PHYSICIAN'S NAME (Type) C. S. CRUMMY, MD		22d. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-19-67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L	23d. LOCATION (City or Town) (County) (State) ARLINGTON FAIRFAX VA.
24. FUNERAL DIRECTOR R. A. POMPHELY 7557 WISCONSIN AVE, BETHESDA, MD.		25a. REC'D BY REGISTRAR SEP 20 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12636

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12645

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day 19 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>Route # 2</u>	
3 NAME OF DECEASED (Type or print) <u>Robert L. Hunt</u>		4 DATE OF DEATH <u>Sept 30 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/30/196</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Hunt</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Howard Hunt - son - same as above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis. Acute</u> DUE TO (b) <u>Ruptured Diverticulum of Bladder</u> DUE TO (c) <u>Prostatic Hypertrophy with obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <u>Recent</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>10/1/67</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		7936 Old Georgetown Road, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	23d. LOCATION (City or Town) (County) (State) <u>Monocacy, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>QCT 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12634											
1. PLACE OF DEATH											
a. COUNTY <u>Montgomery</u> MARYLAND											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>											
c. LENGTH OF STAY IN b. <u>21 days</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>											
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75</u>											
d. STREET ADDRESS <u>239 Mylin St.</u>											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Hunter</u> Middle <u>Hunter</u> Last <u>Hunter</u>											
DATE OF DEATH <u>Sept 14 1967</u>											
4. SEX <u>Male</u> 5. COLOR OR RACE <u>Negro</u> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/22/1902</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Sanitary Concession</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Key West, Fla.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Bentham James Hunter</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>204-01-1579</u> 17. INFORMANT <u>Bertha Hunter - 239 Mylin St.</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>											
DUE TO (b) <u>Cerebral Arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <u>8-24-1967</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>202 Martin Ln., Rockville, Md.</u> 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>8-24-1967</u> to <u>9-14-67</u> , that (I) (we) last saw the deceased alive on <u>9-13-1967</u> , and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Clive E. Jackson</u> M.D. 22b. DATE SIGNED <u>9-14-67</u>											
22c. PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u> 22d. ADDRESS <u>202 Martin Ln., Rockville, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>9-19-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Mem. Pk., Gaithersburg, Md.</u> 23d. LOCATION (City, town or county) (State) <u>Berks Co., Pa.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Lynch</u> ADDRESS <u>2463 Druid Hill Ave. Balt.</u> 25a. REC'D BY REGISTRAR <u>SEP 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

MEDICAL CERTIFICATION

12638

CERTIFICATE OF DEATH

12647

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>2-WEEKS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2828 RADIUS ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>MILTON</u> Last <u>HURLEY</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>6</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/15</u>
9a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>	9. AGE (In years last birthday) yrs <u>52</u>
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Post Office</u>	11. BIRTHPLACE (County & State or foreign country) <u>Washington, D. C.</u>
13. FATHER'S NAME <u>John Walter Hurley</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Berry</u>	
16. SOCIAL SECURITY NO. <u>577-10-3601</u>		17. INFORMANT <u>Mary Hurley 2828 Radius Rd., Wheaton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>14 d.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>67</u> , to <u>9/6</u> , 19 <u>67</u> that (I) (not) last saw the deceased alive on <u>9/6</u> , 19 <u>67</u> and that death occurred at <u>1:30</u> P.M. from causes and on the date stated above			
22a. SIGNATURE <u>William J. Aud</u> M.D.		22b. DATE SIGNED <u>9/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William J. Aud, M.D.</u>		22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Thorn & Thorn, 2434 Georgia Avenue, Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12633

CERTIFICATE OF DEATH

12648

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 14207 Chadwick Lane	
3 NAME OF DECEASED (Type or print) Lena		4 DATE OF DEATH Month September Day 26 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/18/95
9a AGE (In years last birthday) 72 yrs		9b IF UNDER 1 YEAR Months 26 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Russia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Abraham Feldman		14 MOTHER'S MAIDEN NAME Rebecca	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Daughter, Mrs. Beatrice Spear		Address 14207 Chadwick Lane Rockville, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) Arterio Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH approx 30 min 7 years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 24, 1967 to Sept 26, 1967 , that (I) (we) last saw the deceased alive on Sept. 24, 1967 , and that death occurred at 7:37 P.M. from causes and on the date stated above.			
22a SIGNATURE Gene U. Cohen M.D.		22b. DATE SIGNED Sept 26, 67	
22c PHYSICIAN'S NAME (Type) Dr. Gene U. Cohen		22d ADDRESS 1106 Spring St. Silver Spring, Md.	

23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9/28/67	23c NAME OF CEMETERY OR CREMATORY King David Mem. Garden Falls Church, Va.	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR ADDRESS 3501 14th Ave NW		25a RECD BY REGISTRAR SEP 29 1967	25b REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH

12649

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		e. STREET ADDRESS 2611 BLUERIDGE AVE.	
3. NAME OF DECEASED (Type or print) PETER William JACKSON		4. DATE OF DEATH Month 9 Day 16 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-31-22
9. AGE (In years last birthday) 44 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer	
11. BIRTHPLACE (County & State, or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jackson		14. MOTHER'S MAIDEN NAME Elspet Pirie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 217-28-2083	
17. INFORMANT Mrs. Eileen Yates		Address 3810 Wexford Drive Kensington, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from January, 1967, to Sept 16, 1967 , that (I) (we) last saw the deceased alive on Sept 16, 1967 , and that death occurred at 12:27 PM , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 9/16/1967	
22c. PHYSICIAN'S NAME (Type) BLAINE H. AITG		22d. ADDRESS 2641 Colesville Rd Silver Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Sept. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Crematory	23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Maryland
24. FUNERAL DIRECTOR W. B. Thomas		25a. REC'D BY REG STRAR SEP 21 1967	
Address John P. Thomas 34 Georgia Ave. Silver Spring, Md.		25b. REG STRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12641

CERTIFICATE OF DEATH

12650

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2915 Landover Street	
3. NAME OF DECEASED (Type or print) Teresa L. JACKSON		4. DATE OF DEATH Month September Day 8 Year 1967	
5 SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 MAY 1965
9. AGE (In years last birthday) 2 yrs		11. BIRTH-PLACE (County & State, or foreign country) Wright-Patt AFB Dayton, Ohio	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aubrey G. JACKSON		14. MOTHER'S MAIDEN NAME Elsie BREWER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Abbrey G. JACKSON		Address Alexandria, Va. 2915 Landover St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Constrictive Pericarditis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that NO (this hospital) attended the deceased from 6 Sep , 1967, to 8 Sep , 1967, that NO (we) last saw the deceased alive on 8 Sep , 1967, and that death occurred at 1:55 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Eugene D. Van Hove</i> MD		22b. DATE SIGNED 9 Sep 1967	
22c. PHYSICIAN'S NAME (Type) E. D. VAN HOVE LCDR MC USN		22d. ADDRESS U.S. Naval Hospitl, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12 Sep 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR IVES FUNERAL HOME 2847 Wilson Blvd.		25a. REC'D BY REGISTRAR SEP 13 1967	
ADDRESS Arlington, Virginia		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

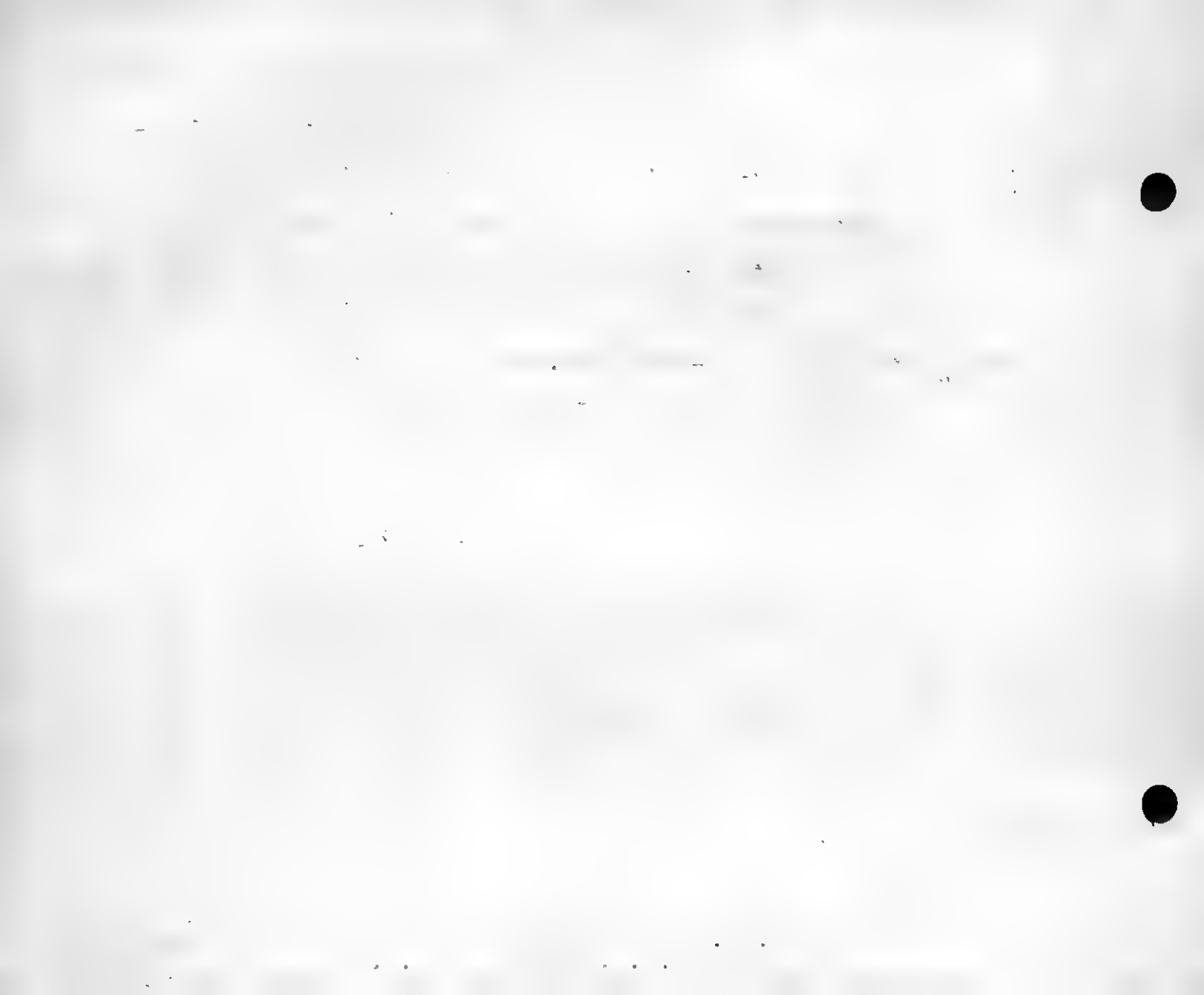
VR A15ME 3
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12651

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>WASHINGTON DC</u> b. COUNTY <u>WASHINGTON DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>5036 FULTON ST. N.W.</u>	
3 NAME OF DECEASED (Type or print) <u>DAVID FRANCIS JAMIESON</u>		4 DATE OF DEATH <u>SEPTEMBER 25 1967</u>	
5 SEX <u>MALE</u>	6 CO. OR OR RACE <u>WHITE</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>63</u> yrs
9 IF UNDER 1 YEAR Months Days Hours		10 IF UNDER 24 HRS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARTOGRAPHIC ENGINEER - Maps Dept. AAA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON, DC</u>	
11 BIRTHPLACE (State or foreign country) <u>WASHINGTON, DC</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>JOHN YOUNG JAMIESON</u>		14 MOTHER'S MAIDEN NAME <u>ANNIE EVANS</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes WW#2</u>		16 SOCIAL SECURITY NO <u>Mr. Catherine Jamieson</u>	
17 INFORMANT <u>Washington DC</u>		Address <u>5036 FULTON ST. N.W.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis Acute</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c) <u>years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Bold</u> M.D.		22. DATE SIGNED <u>9/25/67</u>	
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>9/28/67</u>	<u>Baltimore National</u>	<u>Baltimore, Maryland</u>
24 FUNERAL DIRECTOR <u>The S. H. Hines Company</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>
<u>2901 14th St. N.W. Washington D.C.</u>		<u>SEP 27 1967</u>	



12543

CERTIFICATE OF DEATH

12652

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 299 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. STREET ADDRESS 3822 Ingalls Avenue	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
NAME OF DECEASED (Type or print) First Susan Middle Diane Last Jessie		4. DATE OF DEATH Month September Day 13 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 August 1957
9. AGE (In years last birthday) yrs 10		10. IF UNDER 1 YEAR Months 13 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lawrence D. Jessie		14. MOTHER'S MAIDEN NAME Mary E. Giles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Atelectasis and pneumonia			
DUE TO			
(b) Undiagnosed disease characterized by			
DUE TO weakness, hypomagnesemia			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 18, 1967 to September, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 13 19 67 , and that death occurred at 5:25 M, from causes and on the date stated above.			
22a. SIGNATURE Paul W. Hathaway		22b. DATE SIGNED 14 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) Paul W. Hathaway, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Sept. 16, 1967		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Concord Met. Cemetery		23d. LOCATION (City or Town) (County) (State) Chatham, Va.	
24. FUNERAL DIRECTOR Everly-Heathley Funeral Home, Alex., Va.		25a. REC'D BY REGISTRAR SEP 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Case discussed with acting coroner (Mr. Rogers) and closed.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G392 9/29/67 ph

CERTIFICATE OF DEATH

12653

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>16 days</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <i>Bethesda Sanitarium</i>		d. STREET ADDRESS <i>3505 - 43rd ave</i>	
3. NAME OF DECEASED (Type or print) <i>Albrian T. Johnson</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>8</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 9, 1901</i>
9. AGE (In years) <i>66 1/2</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lockwood Dental Lab.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Nora Wilson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>Yes WWII</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Susan C. Muschlitz (above a d)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia</i> (Sister) dress) DUE TO (b) <i>Bronchogenic carcinoma</i> DUE TO (c) <i>5 months</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Chronic alcoholism, ureteropyelostomy - coarctation</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>A.P.M.</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (If (his hospital) attended the deceased from <i>8/23</i> , 1967, to <i>9/8</i> , 1967, that (I) (we) last saw the deceased alive on <i>8/31</i> , 1967, and that death occurred at <i>9:30 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Allen J. Neill</i>		22b. DATE SIGNED <i>9/8/1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		22d. ADDRESS <i>8601 Old Georgetown Rd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/12/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Ivy Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Upperville, Va.</i>	
24. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>		25. REC'D BY REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>Mt. Rainier, Maryland</i>		DATE <i>SEP 15 1967</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1, and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12645		12654	
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #3 Box 252		d. STREET ADDRESS RFD #3 Box 252	
3. NAME OF DECEASED (Type or print) Elmer A. Johnson		4. DATE OF DEATH Month September Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3, 1898
9. AGE (In years last birthday) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Digger		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph E. Johnson		14. MOTHER'S MAIDEN NAME Laura A. Foster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 441-03-0764	
17. INFORMANT Richard N. Johnson - same item #2 - Son		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 3 hours		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19 57 , to Present , that (I) (we) last saw the deceased alive on Apr. 16, 1967 , and that death occurred at 2:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 9-30-67	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS 105 Russel Ave., Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/4/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Prince George Md	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR Oct 3 1967	
ADDRESS 1331 Rock. Pike Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
12655															
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY _____											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. LENGTH OF STAY IN ID 2 1/2 mos.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) University Nursing Home, 901 Argola Rd.				d. STREET ADDRESS 1414 Saratoga Ave. N.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Gershom Clark Johnston				4. DATE OF DEATH Sept. 25 1967				5. SEX Male 6. COLOR OR RACE Wh. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.- Auditor				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.				11. BIRTHPLACE (County & State, or foreign country) St. Johns, Canada				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Johnston				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 089-14-49358 17. INFORMANT Fanny G. Johnston, Wife, Sams as #2 Address _____							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA & acute Congestive failure + 221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cerebral Thrombosis DUE TO (c) AscVD & Cerebral Vasc Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Urinary infection INTERVAL BETWEEN ONSET AND DEATH 2 days															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from Aug , 1967, to Sept 25 , 1967, that (I) (we) last saw the deceased alive on Sept 25 , 1967, and that death occurred at 0447 PM , from the causes and on the date stated above.															
22a. SIGNATURE Russell C. Bufalino				22b. DATE SIGNED Sept 26, 1967				22c. PHYSICIAN'S NAME (Type) Russell C. Bufalino				22d. ADDRESS 1429 Univ. Blvd. W. SILVER Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 9/27/67				23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION (City, town or county) Suitland, Md.			
24. FUNERAL DIRECTOR Joseph GAWLERS Sons				25a. REC'D BY REGISTRAR SEP 28 1967				25b. REGISTRAR'S SIGNATURE g Charles Judge							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

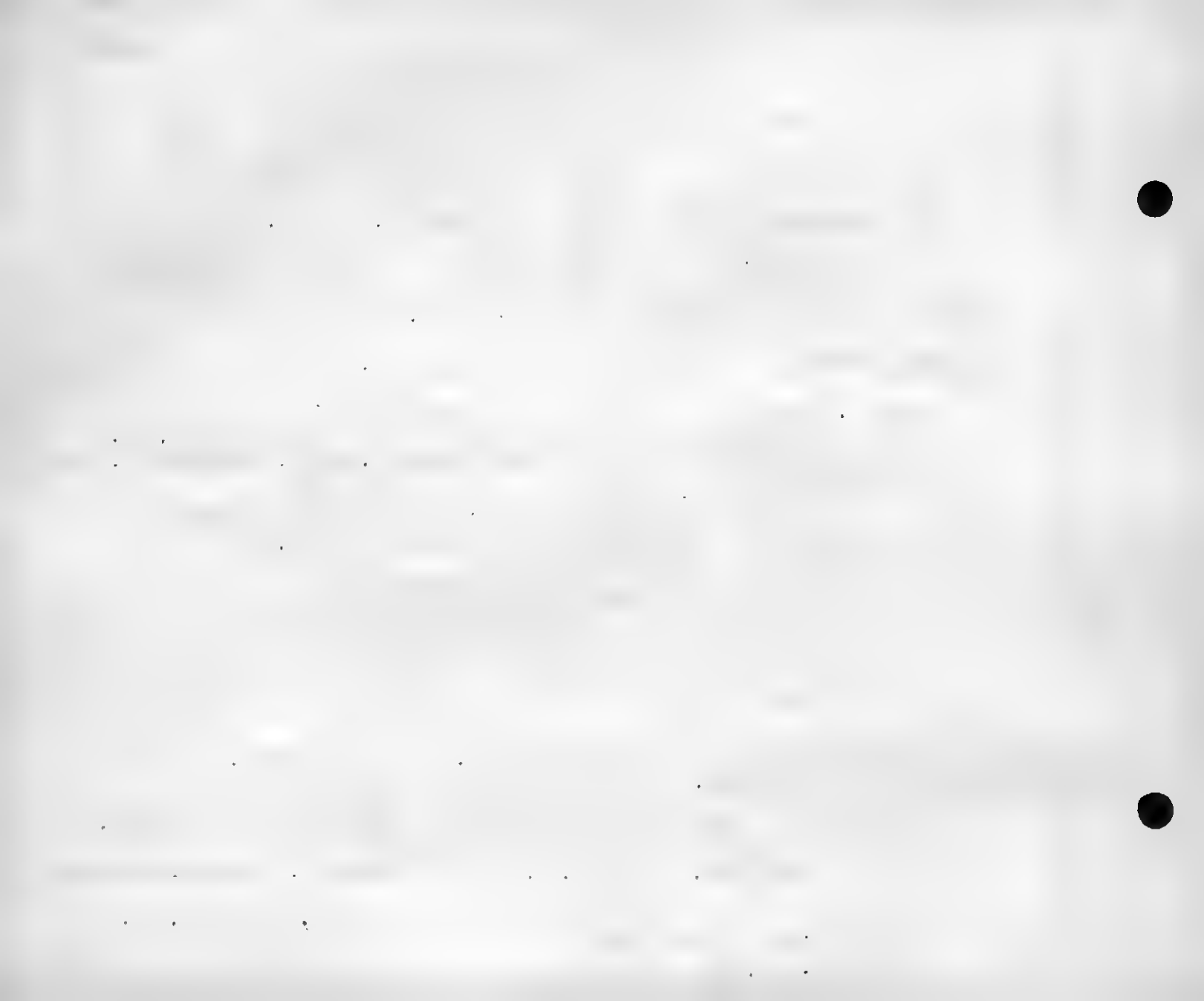
VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #236 Film #3002 9/13/67 ch

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Route 1, Box 433, Lot 53	
3. NAME OF DECEASED (Type or print) Lorraine Irene JONES		4. DATE OF DEATH Month September Day 6 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1934
9. AGE (In years lost birthday) 33 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A (housewife)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Drury		14. MOTHER'S MAIDEN NAME Eva Dubroski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lot 53 Lexington Park, Md. AZ1 Richard E. Jones, USN, Route 1, Box 433		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute bilateral pyelonephritis DUE TO (b) Secondary to radiation cystitis with obstruction DUE TO (c) ureteral vesicle junction bilateral. Secondary to carcinoma of cervix PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year: Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from Aug. 24 , 19 67 , to Sept. 6 , 19 67 , that (X) (we) last saw the deceased alive on Sept. 6 , 19 67 , and that death occurred at 700AM , from causes and on the date stated above.	
22a. SIGNATURE Lawrence A. Jones, M.D.		22b. DATE SIGNED 6 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence A. Jones, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park National Cemetery, Baltimore, Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Mattingly Funeral Home Leonardtwn, Maryland		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. PHYSICIAN'S SIGNATURE Lawrence A. Jones		25c. DATE	

12656



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Fillm 394
11-14-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12848

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12657

1. PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>D.C.</u> b COUNTY <u>✓</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>Washington</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Mitchell S Jones</u>		4 DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1967</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-16-49</u>
9 AGE (In years last birthday) <u>18</u> yrs		10 IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11 BIRTHPLACE (State or foreign country) <u>D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Newton Jones</u>		14 MOTHER'S MAIDEN NAME <u>Marjorie Clyburn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>Margaret L. Jones Alexandria Va</u>	
17 INFORMANT <u>Margaret L. Jones Alexandria Va</u>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple extreme skull fractures</u>		INTERVA. BETWEEN ONSET AND DEATH	
(b) <u>incurred in auto accident</u>			
(c) <u>stating the underlying cause last.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 8) <u>Hit by car involved in auto accident at high rate of speed.</u>	
20c TIME OF INJURY Month, Day, Year <u>3:30 PM 9 10 1967</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) <u>Street</u>		20f (City or town) <u>Takoma Park</u> (County) <u>MD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		22. DATE SIGNED <u>9-10-67</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		23a BIRTHPLACE (City or town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>	
23b DATE THEREOF <u>Sept 13, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>	
23d LOCATION (City or town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>		24 FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>	
25a REC'D BY REG. STRAR <u>SEP 14 1967</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12658

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>14215 London Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilene Virginia Jones</u>		4. DATE OF DEATH Month Day Year <u>9 10 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26-49</u> 18
9. AGE (In years last birthday) yrs <u>18</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired) <u>Stenographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. Co. Gov't.</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William R. Jones</u>	
14. MOTHER'S MAIDEN NAME <u>Virginia C. Cox</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO <u>218-54-8437</u>		17. INFORMANT Address <u>William R. Jones - Father - same item #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple, extreme fractures of skull</u> <u>834.4</u> DUE TO (b) <u>incurred in auto accident</u> Conditions, if any, on which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u>			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Rolling over 20 ft high table at spread</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:30 am 9-10 1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Street</u>	20f. (City or town) (County) (State) <u>Takoma Park Montg. Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>		22. DATE SIGNED <u>7-10-67</u>	
EXAMINER'S NAME (Type) <u>John S. Rogers, M.D.</u>		Address (Street, city, town, or county) <u>1918 Pennsylvania Ave. S.W. Wash. D.C.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/13/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	23d. LOCATION (City or town) (County) (State) <u>Prince George Co., Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		Address <u>1551 Rock Pike Rockville, Maryland</u>	25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

12659

12650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY in lb 53 Days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Michigan		b. COUNTY Mason		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ludington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland						d. STREET ADDRESS Route 2, Dicker Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print)		First Peter		Middle (NMN)		Last Jorgensen		4. DATE OF DEATH Month September 8		Day 1967	
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 9 May 1908		9 AGE (In years last birthday) 59 yrs		10 UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Pilot) American Seaman				10b. KIND OF BUSINESS OR INDUSTRY Shipping		11 BIRTHPLACE (County & State, or foreign country) Denmark				12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hans Jorgensen						14. MOTHER'S MAIDEN NAME Anna Kundsén					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 711-01-8379		17 INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Soft Tissue & Probable bone infection DUE TO Blast crisis (c) Chronic Myelogenous Leukemia/										INTERVAL BETWEEN ONSET AND DEATH Hours 5 Days 50 Days 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour 'o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that (X) (this hospital) attended the deceased from 17 July, 1967, to 8 September 1967, that (X) (we) lost saw the deceased alive on 8 September 1967, and that death occurred at 6:30M, from causes and on the date stated above.											
22a. SIGNATURE C. M. Haskell MD						M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 8 Sept. 1967			
22c. PHYSICIAN'S NAME (Type) Charles M. Haskell, MD.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Burial-transit 9-9-67		23c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery				23d. LOCATION (City or Town) (County) (State) Ludington, Michigan			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland						25a. REC'D BY REGISTRAR SEP 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. In any event, within 72 hours after death.

M

12651

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12660

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>16 hours</u>		d. STREET ADDRESS <u>8013 TAKOMA AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH SAN & HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOHN LEO JUNG HANS</u>		4 DATE OF DEATH Month Day Year <u>9 24 19 67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1893</u>
9. AGE (in years last birthday) <u>73</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED, Supt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK JUNG HANS</u>		14. MOTHER'S MAIDEN NAME <u>BRIDGET Spain.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>ARMY WWI</u>		16. SOCIAL SECURITY NO <u>578-07-9380</u>	
17. INFORMANT <u>Count</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u> DUE TO (b) <u>Gastrointestinal bleeding</u> DUE TO (c) <u>Carcinoma of the stomach</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour "o m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-23</u> , 19 <u>67</u> , to <u>9-24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-23</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>B. G. Bendler</u>		22b. DATE SIGNED <u>9-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. G. Bendler</u>		22d. ADDRESS <u>10820 Ga. Ave, Wheaton, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton, Md.</u>
24. FUNERAL DIRECTOR <u>Chamberlain</u>		25a. REC'D BY REGISTRAR <u>Silver Spring, Md.</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

CERTIFICATE OF DEATH

12661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY in 1b 46 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE			
f. STREET ADDRESS 13022 7th Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALMA First GERTRUDE Middle KELBAUGH Last				4. DATE OF DEATH Month SEPT Day 13 Year 1967			
5. SEX FE		6. COLOR OR RACE WH		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/12/03	
9. AGE (In years lost birthday) 64 yrs		10. IF UNDER 1 YEAR Months 8 Days 2 Hours 0 Min 0		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife			
13. FATHER'S NAME JAMES E. THIRLES				14. MOTHER'S MAIDEN NAME MARY GUNDLING			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO 578-05-1304		17. INFORMANT HOSPITAL RECORDS Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Cardiovascular Dis DUE TO (c) 8 mo Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) At Takoma minimum							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1- , 19 67 , that (I) (we) last saw the deceased alive on 9-13 , 19 67 , and that death occurred at 10:30 AM from causes and on the date stated above.							
22a. SIGNATURE Janet H. C. [Signature]				22b. DATE SIGNED 9-14-67		22c. PHYSICIAN'S NAME (Type) Dr. [Signature]	
22d. ADDRESS 7711 Carroll Ave Takoma Park 12, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 16, 1967		23c. NAME OF CEMETERY OR CREMATORY Whitfield Cemetery		23d. LOCATION (City or Town) (County) (State) Lanham Pro Geo Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR SEP 19 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

FOR STATE
HEALTH DEPT.

12653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12662

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (When deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c LENGTH OF STAY In 1b <u>2 1/2 MOS.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1506 Bridley Lane</u>		d STREET ADDRESS <u>1506 Bridley Lane</u>	
3 NAME OF DECEASED (Type or print) <u>LOVELLA M. KELLER</u>		4 DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Fe</u>	6 COLOR OR RACE <u>Cauc.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>NOV. 18, 1909</u>
9 AGE (In years last birthday) <u>57</u> yrs		10 IF UNDER 1 YEAR Months <u>5</u> Days <u>7</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (State or foreign country) <u>OHIO</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>JOHN WM. RUSH</u>		14 MOTHER'S MAIDEN NAME <u>MARY CAMPBELL</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. A. SECURITY NO. <u>No</u>	
17 INFORMANT <u>12430 DEWEY RD., S.E.</u> <u>WALTER RUSH, (BROTHER)</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) <u>Coronary artery heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Peapack</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. PEAPACK, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b DATE THEREOF <u>Oct. 2, 1967</u>	
22c NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>	
22e ADDRESS <u>C. Glen Carter 8434 Georgia Ave. Warner E. Humphrey, Inc. Silver Spring, Md.</u>		22f REC'D BY REGISTRAR <u>9-26-1967</u>	
22g REGISTRAR'S SIGNATURE <u>Charles Young</u>			

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18-21 Film 393
9-26-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12663

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>309</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>7513 Jackson Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Paul Leslie Kelley</u>				4. DATE OF DEATH <u>9</u> Month <u>1</u> Day <u>1967</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-19</u> 47 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Customs Officer U.S. Gov't</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leslie Kelley</u>				14. MOTHER'S MARRIED NAME <u>Marguerite Penn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>				16. SOCIAL SECURITY NO <u>218-14-5110</u>		17. INFORMANT <u>Georgetta B. Kelley</u> Address <u>7513 Jackson Ave. K.P.K. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>970.2</u> IMMEDIATE CAUSE (a) <u>Pharmacy</u> Barbiturate poisoning DUE TO (b) <u>Overdose of barbiturates</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Took overdose of sleeping pills</u>			
20c. TIME OF INJURY Month, Day, Year <u>3:00</u> <u>Sept 1</u> <u>1967</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
				20f. (City or town) <u>Takoma Park</u> (County) <u>Montg.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/2/67.</u>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 7, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>E. Carter</u> <u>8434 Georgia Avenue</u>				25a. RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Jarner E. Humphrey, Inc. Silver Spring, Md.</u>				DATE <u>SEP 8 1967</u>		<u>John G. Ball</u>	

CERTIFICATE OF DEATH

12655

12664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admiss on) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooke Grove Foundation</u>	
c. LENGTH OF STAY IN lb <u>3 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>Olney</u>	
3. NAME OF DECEASED (Type or print) <u>Harold Ada Amanda Ker Kow</u>		4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-12-81</u>
9. AGE (in years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. 17</u>	
13. FATHER'S NAME <u>George Denton</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>566-16-0777</u>	
17. INFORMANT <u>Washington Sanitarium - records</u>		Address <u>Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Aspiration</u> DUE TO <u>Cerebrovascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u> </u> (c) <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I) (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. B.T.N.G. <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Sept 8</u> , 19 <u>66</u> to <u>Sept 9</u> , 19 <u>67</u> that (if we) last saw the deceased alive on <u>Sept 9</u> , 19 <u>67</u> , and that death occurred at <u>11:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert E. Wilhelm</u>		22b. DATE SIGNED <u>Sept 11, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert E. Wilhelm</u>		22d. ADDRESS <u>4308 Suitland Rd Suitland Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9-12-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>		25a. REC'D BY REG-STRAR <u>SEP 13 1967</u>	
4308 Suitland Rd Suitland Maryland		25b. REG STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12656

12665

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
c. LENGTH OF STAY IN 15 <u>8 months</u>		d. STREET ADDRESS <u>1901 Dayton St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara B Kern</u>		4. DATE OF DEATH <u>Sept 3 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1883</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Allice Allie J. Stogner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-56-7481-T</u>	
17. INFORMANT <u>Mr. Cecil Kern 1901 Dayton St. S. S., Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT (THROMBOSIS)</u> RECURRENT			
DUE TO (b) <u>ARTERIO SCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>INDEFINITE</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RIGHT POST-OP STATUS (12/66), REDUCTION INTER-TROCHANTERIC FRACTURE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/19/66</u> to <u>9/3/1967</u> , that (I) (we) last saw the deceased alive on <u>9/13 1967</u> and that death occurred at <u>4:35 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Lawrence D. Marcus</u> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAWRENCE D MARCUS, M.D.</u>		22d. ADDRESS <u>1111 SPRING STREET, SILVER SPRING, MD 20910</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Sept. 5, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>3201 Bladensburg Rd. D.C.</u>
24. FUNERAL DIRECTOR <u>Glen Carter</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Yunge</u>
Warner E. Humphrey Inc. 8434 Georgia Ave S.S.			

12657

CERTIFICATE OF DEATH

12666

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Yakoma			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL				e. STREET ADDRESS 7113 Woodland Avenue			
3. NAME OF DECEASED (Type or print) First Russell Middle G. Last Kilby				4. DATE OF DEATH Month SEPT Day 26 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-3-07	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months 26 Days 19 Hours 67 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
10b. KIND OF BUSINESS OR INDUSTRY Self-Employed			11. BIRTHPLACE (County & State, or foreign country) Culpeper Co. VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Juber Kilby				14. MOTHER'S MAIDEN NAME Lela Sherman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 224-28-1171		17. INFORMANT Russell G. Kilby Jr. Address 7113 Woodland Ave. Takoma Park, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG METASTASIS DUE TO (b) WITH DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 YEARS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RT. PNEUMONECTOMY WITH THORACOPLASTY 1962							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 7/19 , 19 67 to 9/26 , 19 67 that (1) (we) last saw the deceased alive on 19 , 19 67 and that death occurred at 7:30 P.M. from causes on and on the date stated above.							
22a. SIGNATURE David Goldenberg				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) DAVID GOLDENBERG				22d. ADDRESS 10620 GEORGIA AVE. SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/30/67		23c. NAME OF CEMETERY OR CREMATORY Fairview		23d. LOCATION (City or Town) (County) (State) Culpeper, Culpeper Va.	
24. FUNERAL DIRECTOR Charles G. Groat				ADDRESS Culpeper, Va.		25a. REC'D BY REGISTRAR OCT 2 1967	
				25b. REGISTRAR'S SIGNATURE Charles G. Groat			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12658

12667

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN TB <u>1 Year 5 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Kensington Gardens Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8109 Fenton Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Emma</u> First <u>D.</u> Middle <u>Kilgore</u> Last f. SEX <u>Female</u> g. COLOR OR RACE <u>White</u> h. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> i. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> j. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> k. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> l. CITIZEN OF WHAT COUNTRY? <u>USA</u>			4. DATE OF DEATH <u>September</u> Month <u>24</u> Day <u>19</u> Year <u>67</u> m. DATE OF BIRTH <u>Dec. 15, 1878</u> n. AGE (in years last birthday) yrs. <u>88</u> o. IF UNDER 1 YEAR Months Days Hours Min.				
13. FATHER'S NAME <u>John Siders</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-50-1784</u> 17. INFORMANT <u>Roy J. Kilgore</u> Address <u>10101 Phoebe Lane, Adelphi, Md.</u>		14. MOTHER'S MAIDEN NAME <u>Mary J. Derr</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>B.R. PNEUMONIA</u> 4221 DUE TO (b) <u>PULMONARY CONGESTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ARTERIO-SCLEROTIC CARDIO-VASC. DIS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>1 WEEK</u> <u>Several</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 9, 1963</u> to <u>9/24, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/22, 1967</u> , and that death occurred at <u>12:25 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>R.S. Williams</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>R.S. WILLIAMS</u> 22d. ADDRESS <u>35 NEW YORK AVE. N.W.</u>				22b. DATE SIGNED <u>9/24/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Sept. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rolling Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Camp Hill, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Cecily G. Carter</u> ADDRESS <u>784 34 Georgia Avenue</u> <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Maryland</u>				25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12668

12659

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitorium & Hospital</u>				d. STREET ADDRESS <u>Apt 302 1401 Oglethorpe St N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Abraham NMN Kreuter</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-11-01</u>	
9. AGE (In years last birthday) <u>66</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>dept- NEW</u>		11. BIRTHPLACE (County & State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>		13. FATHER'S NAME <u>Sigmund Kreuter</u>		14. MOTHER'S MAIDEN NAME <u>Esther Klinkenstein</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>062-05-3567</u>		17. INFORMANT <u>patient's chart.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 720.1 DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pulmonary emboli suspected</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> , 19 <u>67</u> to <u>9-28</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-28</u> , 19 <u>67</u> , and that death occurred at <u>2:05</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Gilbert B. Cushner</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gilbert B. Cushner</u>				22d. ADDRESS <u>11161 New Hampshire Ave.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-29-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth David Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Elmont, L. I., New York</u>	
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217 9th Street N.W.</u>				25a. REC'D BY REG STRAR <u>DAVID 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12660

12669

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. STREET ADDRESS <u>8715 Hempstead Ave</u>	
3 NAME OF DECEASED (Type or print) <u>Henry Frederick Krueger</u>		4 DATE OF DEATH <u>9-3-67</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-23-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
3 FATHER'S NAME <u>Henry L. Krueger</u>		14 MOTHER'S MAIDEN NAME <u>Minnie Krueger</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes Army</u>		16 SOCIAL SECURITY NO <u>NO</u>	
17 INFORMANT <u>Address</u>		18	
19 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/3/67</u>	
		Address (Street, city, town or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>9/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Geo. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>12661</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>12670</div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			c. LENGTH OF STAY IN 1b <u>years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3015 Edgewood Rd.</u>					d. STREET ADDRESS <u>3005 Edgewood Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>S.</u> Last <u>KUSHIDA</u>					4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Oriental</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 27, 1904</u>	9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Tokyo, Japan</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>			
13. FATHER'S NAME <u>Shobel Kushida</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>55-10-5100A</u>		17. INFORMANT <u>Wife</u> <u>Hazel Kushida</u>		Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Malnutrition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinomatosis (Primary of Lower Esophagus)</u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>August 12, 1967</u> , to <u>Sept 13, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 11, 1967</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert T. Thibadeau</u>		22b. DATE SIGNED <u>Sept 13, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau</u>		22d. ADDRESS <u>11,000 Old Georgetown Road</u> <u>Rockville, Maryland 20852</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-16-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>			

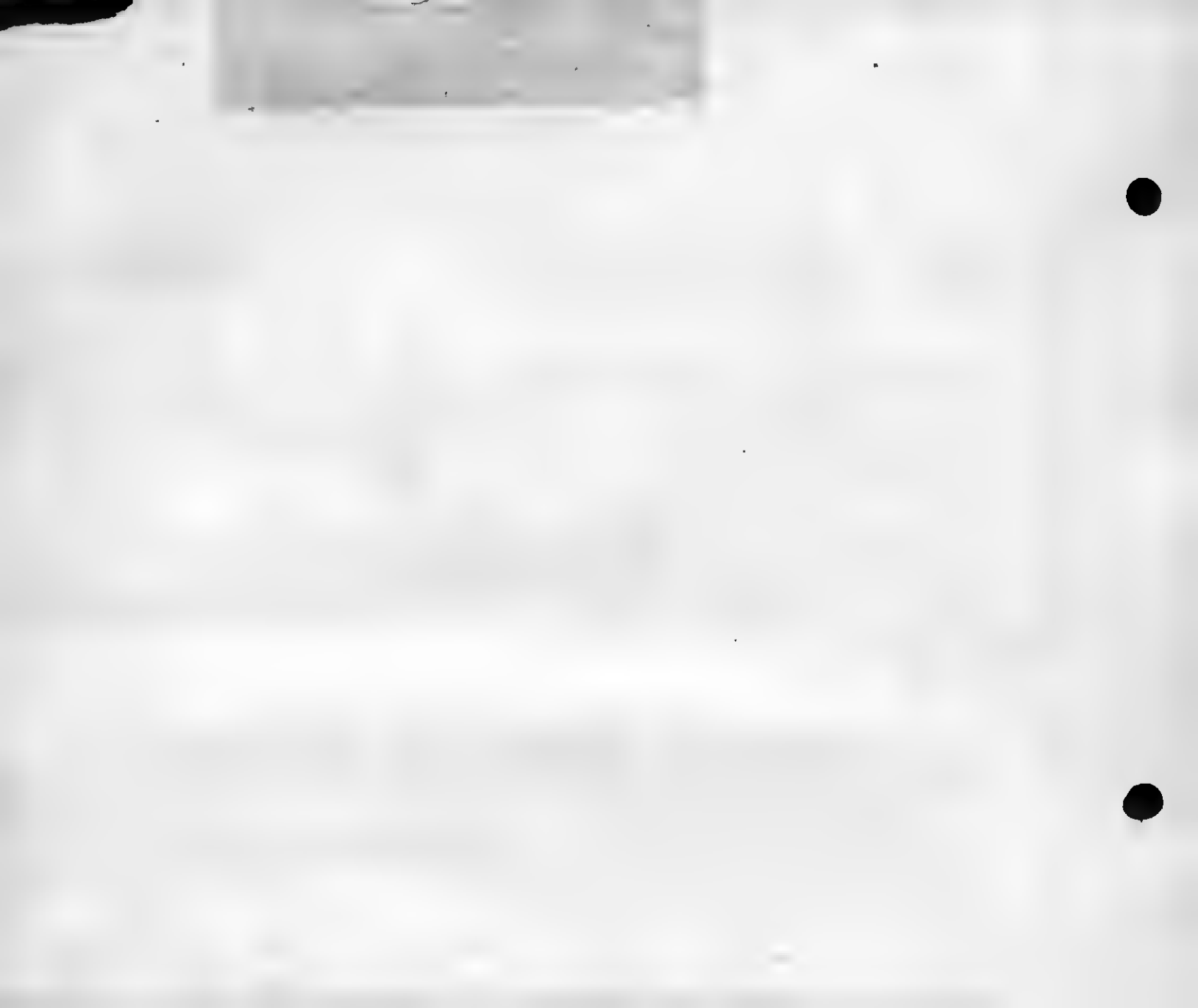
CERTIFICATE OF DEATH

12671

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>one month</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium</u>		d. STREET ADDRESS <u>2252 Nichols Ave. S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Isadore</u> First <u>Kushner</u> Middle Last		4. DATE OF DEATH <u>September 28</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1913</u>
9. AGE (in years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Store Owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MAX Kushner</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca INBINDER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Joyce K. TROSHINSKY</u>		Address <u>Bethesda, Md. 6300 CARNEGIE DR.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> 2. <u>X</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decubitus ulcer, sacrum</u> OUE TO (c) <u>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, cerebral</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 1967</u> to <u>Sept 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 24</u> 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Richard Kaufman</u>		22b. DATE SIGNED <u>9/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD KAUFMAN</u>		22d. ADDRESS <u>916 19th ST NW WASH., DC.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt Lebanon Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>
24. FUNERAL DIRECTOR <u>B. Sannarsky & Sons</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67



12663

CERTIFICATE OF DEATH

12672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Echo		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1- Tuttonwood Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Ana S. Kybal		4 DATE OF DEATH Month 9 Day 28 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 25, 1873
9 AGE (In years last birthday) 94 yrs		IF UNDER 1 YEAR Months 28 Days 28 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Mexico		12. CITIZEN OF WHAT COUNTRY? Mexico	
13. FATHER'S NAME Francisco Raymundo		14. MOTHER'S MAIDEN NAME Augustine Aguilar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 559-70-7883	
17. INFORMANT Son		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic Pyelonephritis DUE TO (c) 6000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 Mo Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 1955 to 9/28 , 1967, that (I) (we) last saw the deceased alive on 9/27 19 67 , and that death occurred at 7:30 AM, from causes and on the date stated above			
22a. SIGNATURE J. A. K. P. Segal		22b. DATE SIGNED 9/28/67	
22c. PHYSICIAN'S NAME (Type) J. A. K. P. Segal		22d. ADDRESS 5323 Conn. Ave NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-29-67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 2 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12664		12673	
CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York	
c. LENGTH OF STAY IN 1b 136 days		d. STREET ADDRESS 14 Monroe Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Argie (NMN) Lagouras		4 DATE OF DEATH Month September Day 21 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 29 August 1939
9. AGE (In years lost birthday) 28 yrs		IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11 BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Michael Lagouras		14. MOTHER'S MAIDEN NAME Patra Chakides	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 059-32-0511	
17. INFORMANT The Medical Records,		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia, terminal aspiration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Malignant carcinoid syndrome with extensive metastatic involvement DUE TO (c) 18 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS A JTDPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 21	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 8, 19 67 , to September 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on September 21 19 67 , and that death occurred at 10:10 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert I. Keimowitz, MD		22b. DATE SIGNED 22 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) Robert I. Keimowitz, MD		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-25-67	23c. NAME OF CEMETERY OR CREMATORY CYPRESS HILL CEM	23d. LOCATION (City or Town) (County) (State) BROOKLYN NEW YORK
24. FUNERAL DIRECTOR W.W. Chambers G 1400 Chapin St NW		25a. RECEIVED BY REGISTRAR SEP 25 1967	
ADDRESS Wash DC.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12665		12674	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>	
c. LENGTH OF STAY IN 1b <u>16 hr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>7520 Maple Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth Amanda Lamar</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-2-88</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NSWf</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Negle</u>		14. MOTHER'S MAIDEN NAME <u>Winters</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>24-14-8387</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>18 hours</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>High Blood Pressure</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>67</u> , to <u>9/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/25</u> , 19 <u>67</u> , and that death occurred at <u>10:10</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>Alan R. Gair</u>		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALAN R. Gair M.D.</u>		22d. ADDRESS <u>7777 Maple Ave, Takoma Park, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/28/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u>
24. FUNERAL DIRECTOR <u>Wm. J. Tucker Sons</u>		25a. RECD BY REGISTRAR <u>SEP 27 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

77

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PESTON STREET, BALTIMORE, MARYLAND 21201											
Item #2c Film #G393 10/19/67 ph											
CERTIFICATE OF DEATH											
12676											
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Mont.</u>					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c LENGTH OF STAY in 1b <u>D.O.A.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>						d STREET ADDRESS <u>8923 Isbell St.</u>					
3. NAME OF DECEASED (Type or print) <u>Eugene F. Langan</u>						4 DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1967</u>					
5. SEX <u>M</u>		6 COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>7-24-1917</u>		9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Safety Consultant U.S. Dept. of Army Civ.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Edward A Langan</u>						14. MOTHER'S MAIDEN NAME <u>Nettie E. Jones</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1942-1956</u>						16. SOCIAL SECURITY NO <u>88-16-4100</u>		17. INFORMANT <u>Wife - Mary Ann</u> Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>Pulmonary edema</u>											
DUE TO (b) <u>emphysema</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>						20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f ((City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>5/1/67</u> , 19 <u> </u> , to <u>Sept 28</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>Sept 27</u> 19 <u>67</u> and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.											
22a SIGNATURE <u>Patrick C. Samelson</u> M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>9/28/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>PATRICK C. SAMELSON</u>						22d ADDRESS <u>11768 Georgia Ave. Spring 972d</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b DATE THEREOF <u>10-2-67</u>			23c NAME OF CEMETERY OR CREMATORY <u>Baltimore Natl Cem.</u>			23d LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>						25a. REC'D BY REGISTRAR <u>DATE OCT 3 1967</u>		25b REG STRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12677

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>DDA</u>		d. STREET ADDRESS <u>6416 Crane Terrace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Bartholomew School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patricia Joseph Dawson</u>		4. DATE OF DEATH <u>Sept. 24 1967</u>	
5. SEX <u>M</u> COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 16-1958</u>		9. AGE <u>8</u> years last birthday yrs IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Lepore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>6416 Crane Terrace</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO (b) <u>20, 4</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>20, 4</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Caught head in Power window of station wagon.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:15 p.m. 9/24 1967</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Residing at</u>	
20e. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Montgomery</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>9/24/67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REG STRAR <u>SEP 29 1967</u>	
ADDRESS		25b. REG. STRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12669

CERTIFICATE OF DEATH

12678

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolsville Rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium Bethesda Md.</u>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First <u>H.</u> Middle <u>LEITH</u> Last		4. DATE OF DEATH <u>Sept 5 1967</u> Month <u>Sept</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 30, 1884</u> 9. AGE (in years last birthday) <u>83</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Leith</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Leith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>819-16-3112</u>	
17. INFORMANT <u>Charles Leith, Boyds, Md</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Circulatory stasis and inactivity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>Several hours</u> <u>many days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Upper respiratory infection; generalized arteriosclerosis</u>			
20a. ACCIDENT: WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> , 1967, to <u>Sept 5</u> , 1967, that (I) <u>did not</u> see the deceased alive on <u>Aug 31</u> , 1967, and that death occurred at <u>6:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>George H. Mitchell</u> M.D.		22b. DATE SIGNED <u>Sept 5, 1967</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/8/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Middleburg</u>	23d. LOCATION (City or Town) (County) (State) <u>Middleburg Va.</u>
24. FUNERAL DIRECTOR <u>William C. Hill</u> ADDRESS <u>Barnwell Rd.</u>		25a. REC'D BY REGISTRAR <u>SEP 11 1967</u> DATE	25b. REGISTRAR'S SIGNATURE <u>g. Charles Judger</u>

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12670

12679

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN TB 1 HOUR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 18600 BROOKE ROAD	
3. NAME OF DECEASED (Type or print) HAROLD DISNEY		4. DATE OF DEATH 9 27 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-21-12
9. AGE (In years, last birthday) 55 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN LETHBRIDGE		14. MOTHER'S MAIDEN NAME ANNIE DISNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-36-5309	
17. INFORMANT MEDICAL RECORD DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 4-20-1 (b) Obstruction of anterior coronary artery DUE TO Arteriosclerotic heart disease (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hrs Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour : m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1967 to 9/27 , 19 67 , that (I) (we) last saw the deceased alive on 9/27 , 19 67 , and that death occurred at 9:30A M, from causes and on the date stated above			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 9-27-67	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Burtonsville	23d. LOCATION (City or town) (County) (State) Burtonsville. Maryland
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR SEP 29 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

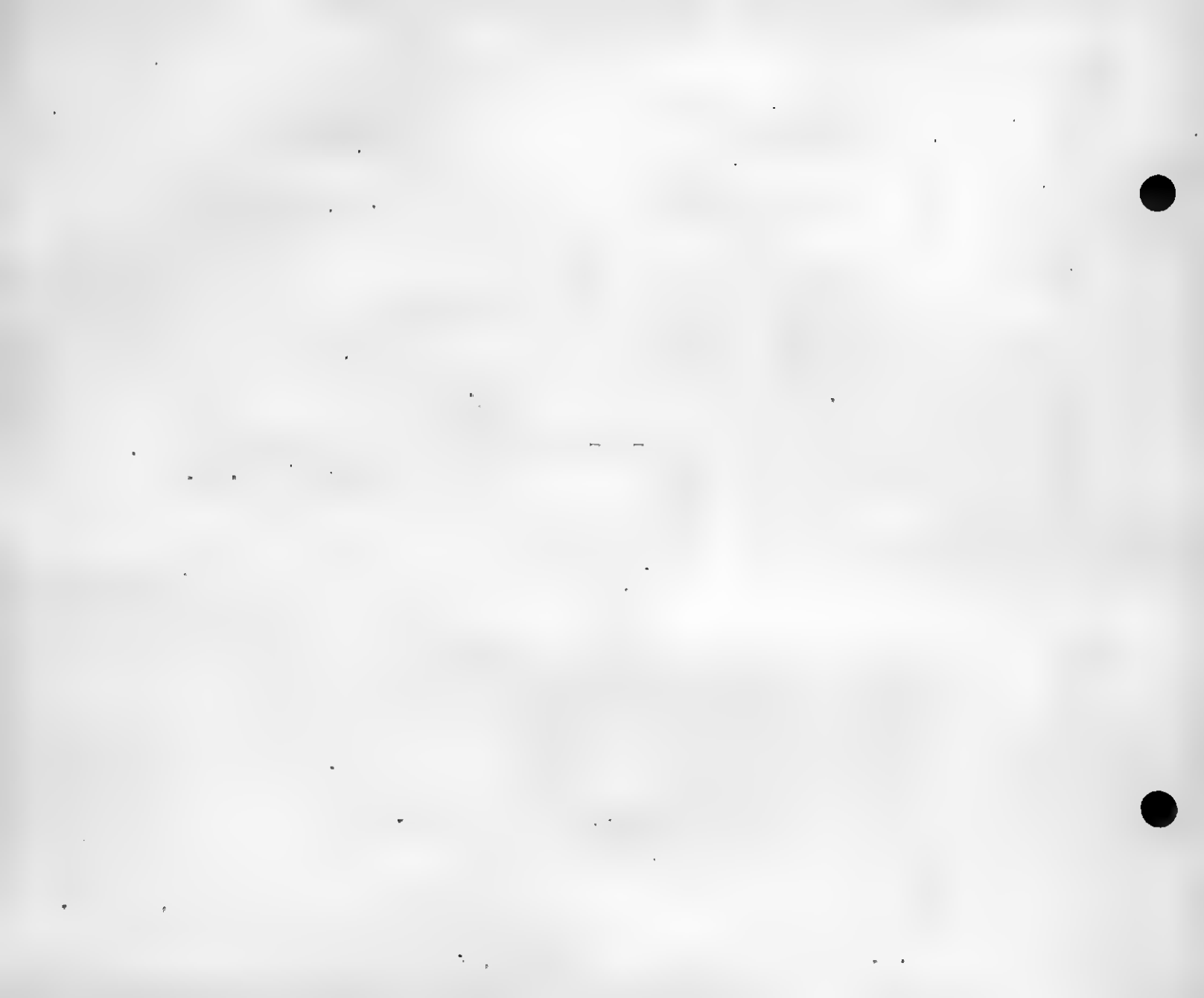
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12671					12680						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						
Montgomery MARYLAND					Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 16609 Jilrick Street					d. STREET ADDRESS 16609 Jilrick Street						
3. NAME OF DECEASED (Type or print) First Middle Last John Penn Lewis					4. DATE OF DEATH Month Day Year 9 13 1967						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/14/1882		9. AGE (in years last birthday) 85 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired from Railroad					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Scranton, Pennsylvania		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William H. Lewis					14. MOTHER'S MAIDEN NAME Mary Powell						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 712-14-4370		17. INFORMANT Walter Lewis-19 Barteau St.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis</u> 42 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> 5 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/10/67, 19 to 9/9/67, 19, that (I) (we) last saw the deceased alive on 9/9/67, 19, and that death occurred at 9:05 AM, from the causes and on the date stated above.											
22a. SIGNATURE A.W. Smith M.D.					22b. DATE SIGNED 9/13/67		22c. PHYSICIAN'S NAME (Type) A.W. SMITH				
22d. ADDRESS 13018 GEORGIA AVE WHEATON, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF 9/14/67		23c. NAME OF CEMETERY OR CREMATORY Laurelwood Cemetery			23d. LOCATION (City, town or county) (State) Stroudsburg, Penna.			
24. FUNERAL DIRECTOR The S.H. Hines Company					ADDRESS Washington, DC		25a. REC'D BY REGISTRAR SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12681

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8315 Brook Lane,				d. STREET ADDRESS 8315 Brook Lane, Apt. 706	
3. NAME OF DECEASED (Type or print) First Martha		Middle Portwood		Last Lewis	
4. DATE OF DEATH Month September		Day 19		Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 21, 1900	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY Federal Government		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William A. Powell		14. MOTHER'S MAIDEN NAME Ida Nave	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-46-4935		17. INFORMANT Sister Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). 1 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Amyotrophic Lateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Sclerosis with Bulbar DUE TO (c) Involvement.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9/21/1967	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-57		23c. NAME OF CEMETERY OR CREMATORY Maple Grove Cem.	
23d. LOCATION (City, town or county) Nicholasville, Kentucky		23e. (State) Kentucky		23f. (County)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 22 1967		25b. REGISTRAR'S SIGNATURE John J. Judd	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12573

CERTIFICATE OF DEATH

12682

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Valley Lee 20692 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Valley Lee 20692 d. STREET ADDRESS Drayden Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Roger Walter Lewis First Middle Last		4. DATE OF DEATH Month Day Year September 16 1967	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1967
9. AGE (In years last birthday) 1 day		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A	
11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Roger M. Lewis		14. MOTHER'S MAIDEN NAME Linda Y. Foard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Roger M. Lewis, Drayden Rd., Valley Lee, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest DUE TO (b) Aortic Valve Stenosis DUE TO (c) Congenital Heart Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from Sept. 15, 1967 , to Sept. 16, 1967 , that (b) (we) last saw the deceased alive on Sept. 16, 1967 , and that death occurred at 9:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED Sept. 18, 1967	
22c. PHYSICIAN'S NAME (Type) F. X. LOERS.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-20-1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road, Baltimore, Maryland		25a. REC'D BY REGISTRAR SEP 20 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION
CLEARED W.R. MEDICAL EXAMINER

Items 1-21 File 394 10-31-67 ams		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		12683	
12674					
1 PLACE OF DEATH a. COUNTY Montgomery			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hosp			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Shawn Presley Leyda			4 DATE OF DEATH Month September 24, 19 67		
5 SEX Male		6. COLOR OR RACE Cau		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH 11/17/64		9. AGE (In years last birthday) 2 yrs		10. UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME James H. Leyda, Jr.		14. MOTHER'S MAIDEN NAME Vivia Brawdy			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT James H. Leyda, Jr., Father	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 413x Sudden Death DUE TO Focal pulmonary atelectasis (b) Pericardial effusion DUE TO Diffuse interstitial pneumonia (c) Myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hydrocephalus				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to Natural, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE Frank Mate, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/25/67	
22c. PHYSICIAN'S NAME (Type) Frank Mate, Jr.		22d. ADDRESS 50 W. Edmondston Drive, Rock. Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/67		23c. NAME OF CEMETERY OR CREMATORY Finleyville	
23d. LOCATION (City or Town) Finleyville, Pa.		(County)		(State)	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		ADDRESS 1331 Rockville Pike Rockville, Md.		25a. RECD BY REGISTRAR DATE SEP 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b Washington D. C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) David S. Liepman		4 DATE OF DEATH Month Sept. Day 27 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1906
9 AGE (in years last birthday) yrs 61		10. UNDER 1 YEAR Months 1 Days 17 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jules Liepman		14. MOTHER'S MAIDEN NAME Hattye Wineberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 652-12-4573	
17. INFORMANT Potomac Valley Rest Home		Address Rockville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myeloid Carcinomatosis due to DUE TO (b) Carcinoma of the Sigmoid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) one year		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Rheumatic Nodular Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1967 to Sept. 24, 1967 , that (I) (we) last saw the deceased alive on Sept. 24, 1967 , and that death occurred at 4 P. M. from causes and on the date stated above			
22a. SIGNATURE Jerome J. Krick		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jerome J. Krick		22d. ADDRESS 3071 Ordway St., Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Kensico Cem.		23d. LOCATION (City or town) (County) (State) Hawthorne N.Y.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR SEP 21 1967	
ADDRESS 1351 Rockville Pike Rockville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12676

12685

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA				c. LENGTH OF STAY IN TB D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				d. STREET ADDRESS 8603 BRADMOOR DRIVE			
3. NAME OF DECEASED (Type or print) EDWARD OWEN LIKENS				4. DATE OF DEATH Month SEPT 17 Year 1967			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT 3, 1901	
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		11. BIRTHPLACE (County & State, or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G.B. LIKENS				14. MOTHER'S MAIDEN NAME RUTH COMBS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. - - -		17. INFORMANT MAE MOUNT LIKENS - WIFE Address SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 4201 Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1963 , to 9-17-67 , that (I) (we) last saw the deceased alive on 9-8-67 , and that death occurred at 9:30 AM , from causes and on the date stated above.							
22a. SIGNATURE D. L. Sengstack M.D.				22b. DATE SIGNED 9-17-67		22c. PHYSICIAN'S NAME (Type) Dr. G. F. Sengstack	
22d. ADDRESS 9241 Columbia Blvd. Silver Sp.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-18-1967		23c. NAME OF CEMETERY OR CREMATORY Hartford Cemetery		23d. LOCATION (City or Town) (County) (State) Hartford, Ky.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.				25a. REC'D BY REGISTRAR SEP 20 1967			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				25c. ADDRESS 5130 Wisc. Ave. N.W. Wash. D.C.			

RELEASED BY DR BELDON REAP MEDICAL EXAMINER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

12686

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Darnestown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kearneysville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. # 28		d. STREET ADDRESS Rural	
3. NAME OF DECEASED (Type or print) ANNIE C. LISKEY		4. DATE OF DEATH Month SEPTEMBER Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1884
9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Haycock		14. MOTHER'S MAIDEN NAME Hannah Ellis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 232-74-2726	
17. INFORMANT Gladys Dunn - Item # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 1967, to Sept 25 , 1967, that (I) (we) last saw the deceased alive on Sept 25 , 1967, and that death occurred at 10:30 AM , from causes on and on the date stated above.			
22a. SIGNATURE John Fawcett		22b. DATE SIGNED 9/25/67	
22c. PHYSICIAN'S NAME (Type) John Fawcett		22d. ADDRESS Dawsonville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/27/67	
23c. NAME OF CEMETERY OR CREMATORY Bakersville		23d. LOCATION (City or Town) (County) (State) Bakersville, Md.	
24. FUNERAL DIRECTOR Melvin T. Strider Company Charlestown, W.Va.		25a. REC'D BY REGISTRAR DATE SEP 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12687

12675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Grove		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington Grove	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Center Street		d. STREET ADDRESS 11 Center Street	
3. NAME OF DECEASED (Type or print) Howard R. Loeffel		4. DATE OF DEATH Month September Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/26/86
9. AGE (In years) 81 yrs		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Loeffel		14. MOTHER'S MAIDEN NAME Elizabeth Perry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-09-9932	
17. INFORMANT Ethel J. Loeffel - wife - same item "2"		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Coronary Atherosclerosis (b) Coronary Thrombosis (c) Coronary Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs 48 hrs 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour 00 m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 66 to 9/11 , 19 67 that (I) (we) last saw the deceased alive on 9/11 , 19 67 , and that death occurred at 11:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Stephen Jones		22b. DATE SIGNED 9/12/67	
22c. PHYSICIAN'S NAME (Type) Stephen Jones		22d. ADDRESS 809 Veire Mill Road, Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/15/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Prince Georges Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REGISTAR'S SIGNATURE SEP 13 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Filed #3392 9/13/67 ph

12679

CERTIFICATE OF DEATH

12688

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
c. LENGTH OF STAY in lb <u>17 yrs</u>		d. STREET ADDRESS <u>12609-Conn. Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12609-Conn. Avenue</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Kudolph Frederick Lohaus</u>		4 DATE OF DEATH Month <u>Sept.</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893 Aug. 30, 1897</u>
9. AGE (In years last birthday) <u>74 yrs</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interior Decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Lohaus</u>		14. MOTHER'S MAIDEN NAME <u>Lena Hagenberg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>579-48-7118</u>	
17. INFORMANT <u>Loretta Lohaus-wife -12609-Conn. Ave.</u>		Address <u>Kensington, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> 5070- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Lung Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u> </u> , 19 <u>66</u> , to <u>9-3</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>9-3</u> 19 <u>67</u> , and that death occurred at <u>7</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>9-4-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602-Ga. Avenue Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Mayville, Wisconsin</u>
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Varner E. Pumphrey, Inc. 8434 Ga. Ave. S. S. Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>W. S. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12580

12689

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE <u>D.C.</u> b COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY in 1b <u>22 days/11 hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium * Hospital</u>				e. STREET ADDRESS <u>2240 Cathedral Ave. N.W.</u>			
3 NAME OF DECEASED (Type or print) <u>ELKA</u> First <u>NMN</u> Middle <u>LORBER</u> Last <u>BAUM</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-88</u> 79 yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWR</u>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>79</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Palestine</u>				12. CITIZEN OF WHAT COUNTRY? <u>NONE</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Schendel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO <u>578-6608642</u>		17. INFORMANT <u>Hospital Records</u> Address <u>7600 Carroll Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>20 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While or work <input type="checkbox"/> Not While <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 7, 1967</u> to <u>SEPT 12 1967</u> , that (I) (we) last saw the deceased alive on <u>SEPT 11 1967</u> , and that death occurred at <u>4:20 AM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Robert K. Krichmar</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>SEPT 12 1967</u>	
22c PHYSICIAN'S NAME (Type) <u>ROBERT K. KRICHMAR MD</u>				22d ADDRESS <u>7733 BLASKA AVENUE N.W. WASHINGTON D.C. 20012</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Sept. 13, 1967</u>		23c NAME OF CEMETERY OR CREMATORY <u>National Capital Hebrew</u>		23d. LOCATION (City or Town) (County) (State) <u>Hillside, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Donald M. Stein Hebrew Memorial</u>				25a REC'D BY REGISTRAR <u>SEP 14 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

12681

CERTIFICATE OF DEATH

12690

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 47 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center		e. STREET ADDRESS 6905 Carleton Terrace	
3 NAME OF DECEASED (Type or print) First Middle Last Betty Zane Love		4. DATE OF DEATH Month Day Year September 30 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 November 1918
9 AGE (In years last birthday) 48 yrs		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife	
11 BIRTHPLACE (County & State, or foreign country) New York		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Schofield		14. MOTHER'S MAIDEN NAME Lottie Loehl	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO Not available	
17 INFORMANT The Medical Records, The Clinical Center, Bethesda, Maryland		20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bacterial Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Soft Tissue Abscess DUE TO (c) Adenocarcinoma of lung with metastases			INTERVAL BETWEEN ONSET AND DEATH 48 hours 1 month 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 15 August, 1967, to 30 September 1967 that (X) (we) lost saw the deceased alive on 30 September 1967, and that death occurred at 3:25 M, from causes and on the date stated above.			
22a. SIGNATURE Thomas P. Clancy		22b. DATE SIGNED Sept. 30, 1967	
22c. PHYSICIAN'S NAME (Type) Thomas P. Clancy, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland
24. FUNERAL DIRECTOR C. Glen Carter		25a. REC'D BY REGISTRAR OCT 4 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12682 CERTIFICATE OF DEATH 12691											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>56 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 82.3					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>						d. STREET ADDRESS <u>702 South Arlington Mill Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Joseph</u> Last <u>Mahoney</u>						4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1934</u>		9. AGE (In years last birthday) <u>33 yrs.</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Economist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Mahoney</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Davitt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Korean</u>				16. SOCIAL SECURITY NO. <u>Not available</u>		17. INFORMANT <u>The Medical Record,</u> Address <u>The Clinical Center, Bethesda, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mycosis Fungoides</u> DUE TO (c) <u>3 Years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>9</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>9</u>			
21. I certify that <u>XX</u> (this hospital) attended the deceased from <u>July 15</u> , 19 <u>67</u> , to <u>September 9</u> , 19 <u>67</u> , that <u>X</u> (we) lost <u>saw</u> the deceased alive on <u>September 9</u> , 19 <u>67</u> , and that death occurred at <u>4:45M</u> , from causes and on the date stated above.											
22a. SIGNATURE <u>Michael Emmer</u>						22b. DATE SIGNED <u>10 Sept. 1967</u>			22c. PHYSICIAN'S NAME (Type) <u>Michael Emmer, MD.</u>		
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9/18/67</u>		23c. NAME OF CEMETERY OR CREMATOR <u>St. Stephens</u>		23d. LOCATION (City or Town) (County) (State) <u>Framingham, Mass.</u>			
24. FUNERAL DIRECTOR <u>W.W. Chambers, Jr.</u> <u>1400 Chapin St. NW Wash, DC</u>						25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MARYLAND STATE DEPARTMENT

12683

CERTIFICATE OF DEATH

12692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by Medical Examiner Dr. John Ball

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>1 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home</u>		d. STREET ADDRESS <u>2009 Blue Ridge Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mayme Markowitz Markheim</u>		4. DATE OF DEATH <u>Sept 2 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Caucas</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/1890</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>Rochester, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Meyer Markowitz</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Witt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR HEMORRHAGE</u> DUE TO (b) <u>HYPERTENSIVE AND ARTERIO-SCLEROTIC VASCULAR DISEASE</u> DUE TO (c) <u>6 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>		19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1963</u> to <u>SEPT 2 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 10 1967</u> , and that death occurred at <u>7 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Robert L. Krichmar MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR MD</u>		22d. ADDRESS <u>7733 ALASKA AVENUE N.W. WASHINGTON D.C. 20012</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FRUMAN PARK CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>SYRACUSE, N.Y.</u>	
24. FUNERAL DIRECTOR <u>Deborah J. Farrell</u>		25a. REC'D BY REGISTRAR <u>4217-9-67</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>		DATE <u>SEP 5 1967</u>	

12684

CERTIFICATE OF DEATH

12693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>35 Mins</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7200 Old Stage Rd</u>	
3 NAME OF DECEASED (Type or print) <u>Grace Marie McAuliffe</u>		4 DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Sept. 24 1911</u>
9. AGE (in years last birthday) <u>55</u> yrs		IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland, Montgomery</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>U. S.</u>	
13 FATHER'S NAME <u>James Edgar Morningstar</u>		14 MOTHER'S MAIDEN NAME <u>Mary Florrie Loy</u>	
15. WAS DECEASED EVER IN U.S. ARMY? (Yes, no, or unknown) (If yes give dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>James S. McAuliffe</u>	
17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>STROKE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>HYPERTENSION + CORONARY DISEASE</u> DUE TO last. (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>See</u> , 19 <u>55</u> , to <u>Aug</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 2 1967</u> , and that death occurred at <u>9:40</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. J. J. Donovan</u>		22b. DATE SIGNED <u>9/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. J. J. DONOVAN</u> <u>8218 WILSON AVE</u>		22d. ADDRESS <u>BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Beallsville, Maryland</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. J. J.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

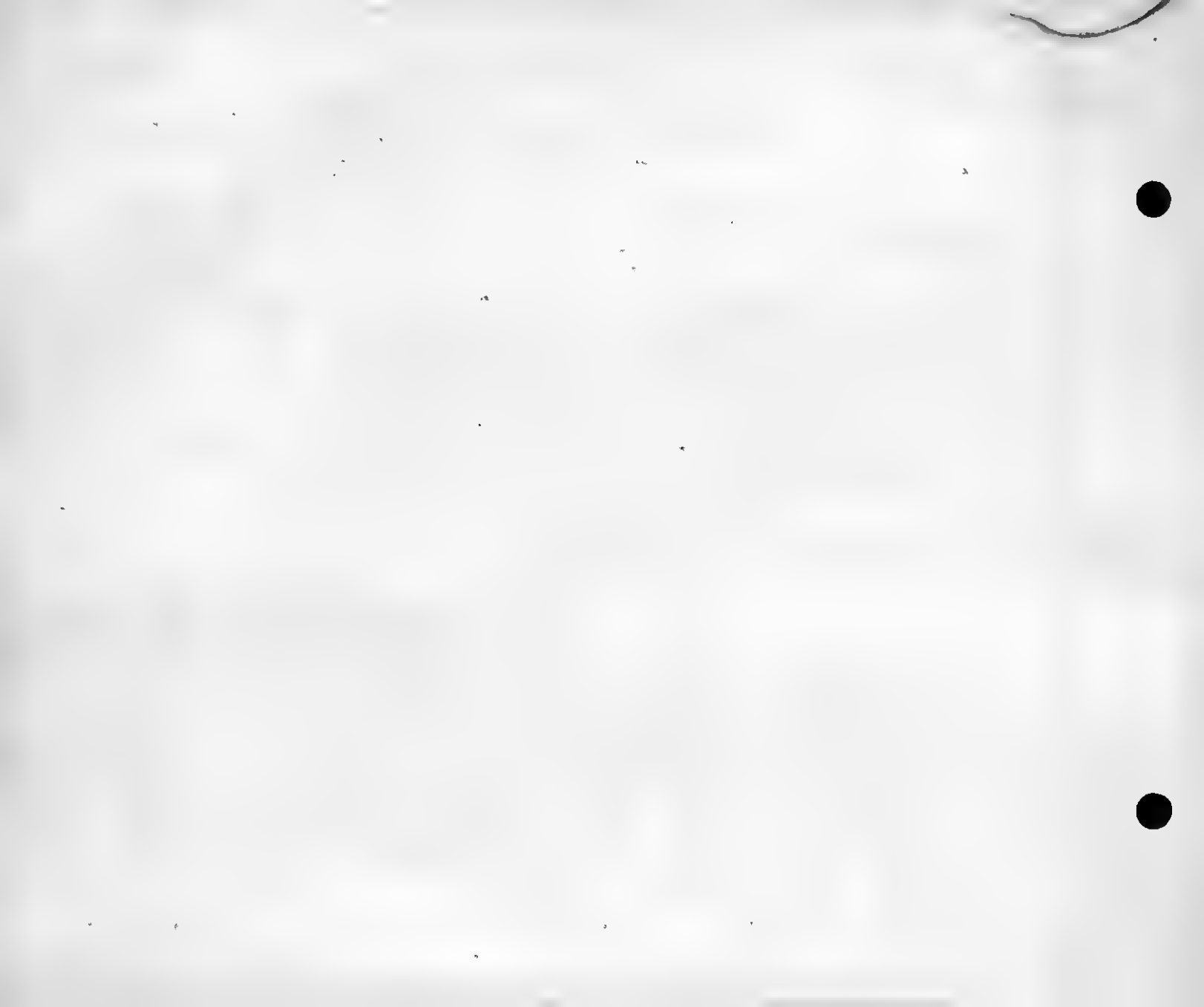
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12686

12694

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>8mo 22da</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>		d. STREET ADDRESS <u>5906 Aberdeen Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Timothy D. McCarthy</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hotel Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>310-09-4443</u>	
17. INFORMANT <u>Daug.</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200 ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS GENERAL</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>YR.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIVERTICULITIS OF COLON, ACUTE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 1964, to <u>SEPT.</u> , 1967, that (I) (we) last saw the deceased alive on <u>SEPT. 17 1967</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Curtis</u>		22b. DATE SIGNED <u>9-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEO M. CURTIS, M.D.</u>		22d. ADDRESS <u>8218 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-20-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>New Haven, Conn.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12686

CERTIFICATE OF DEATH

12695

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN It Silver Spring,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital				d. STREET ADDRESS 10110 New Hampshire Ave			
3 NAME OF DECEASED (Type or print) WILLIAM PAUL McCLELLAND				4. DATE OF DEATH Month Sept. Day 9, Year 1967			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 27, 1918	
9 AGE (In years birthday yrs) 48		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Penna.	
12 CITIZEN OF WHAT COUNTRY? U. S.							
13 FATHER'S NAME Daniel Clark McClelland				14 MOTHER'S MAIDEN NAME Mary G. Brady			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes				16 SOCIAL SECURITY NO 72-16-1310		17 INFORMANT wife Amelia R. McClelland Address Same as Item 2.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				(b) Acute Myocardial Infarction - Inferior wall. Arteriosclerotic Heart Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o m p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-8 , 19 67 , to 9-9 , 19 67 , that (I) (we) saw the deceased alive on 9-8 , 19 67 , and that death occurred at 12:01 A.M. from causes and on the date stated above.							
22a SIGNATURE J. Blaine Fitzgerald M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 9-9-67	
22c. PHYSICIAN'S NAME (Type) J. BLAINE FITZGERALD				22d. ADDRESS 8218 Wisconsin Ave. Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-67		23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		23d. LOCATION (City or Town) (County) (State) New Bethlehem, Penna	
24 FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda, Maryland				25a REC'D BY REGISTRAR SEP 14 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12687

CERTIFICATE OF DEATH

12696

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared by coroner - Dr. John Ball

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10703 Tenbrook Drive</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10703 Tenbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Pidellis</u> Last <u>Mc Intire</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 12, 1897</u>
9 AGE (In years last birthday) <u>70</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Accountant</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13 FATHER'S NAME <u>William Scott Mc Intire</u>		14 MOTHER'S MAIDEN NAME <u>Olive Modessett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>yes</u>	
17. INFORMANT <u>Edna J. Mc Intire</u>		Address <u>10703 Tenbrook Drive Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>15 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>35 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1967</u> , to <u>Aug 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Aug 23, 1967</u> , and that death occurred at <u>8:30 A.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>George B Patrick Jr.</u> M.D.		22b. DATE SIGNED <u>Sept 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>George B Patrick Jr.</u>		22d ADDRESS <u>9221 Colesville Rd Silver Spring, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>Sept. 7, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24a FUNERAL DIRECTOR <u>C. Glen Carter</u> ADDRESS <u>8434 Georgia Avenue</u>		25a REC'D BY REGISTRAR <u>SEP 8 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>
24b <u>Warner E. Pumphrey, Inc.</u> <u>Silver Spring, Md.</u>			

CERTIFICATE OF DEATH

12697

12685

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if at institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		d. STREET ADDRESS <u>8004 Park Crest Drive</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank Joseph McKenna</u>		4. DATE OF DEATH <u>September 10 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-84</u>
9. AGE (In years lost birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Etcher of Silver</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Connecticut</u>	
13. FATHER'S NAME <u>Christopher McKenna</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Owens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>042-05-2934</u>	
17. INFORMANT <u>William J. McKenna</u> Address <u>8004 Park Crest Drive, Silver Spring, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>250</u>	
(b) <u>Chronic myocardial infarction</u>			
(c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Brain aneurysm</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MED. CA. EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>65</u> , to <u>Sept 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-9</u> , 19 <u>67</u> , and that death occurred at <u>2A</u> -M, from causes on and on the date stated above.			
22a. SIGNATURE <u>John S. Rogers M.D.</u>		22b. DATE SIGNED <u>9-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John S. Rogers M.D.</u>		22d. ADDRESS <u>2250 Wisconsin Ave. N.W.</u>	
23a. BURIAL, CREMATION, or other disposal (Specify) <u>burial</u>	23b. DATE THEREOF <u>Sept. 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Wheaton, Montgomery, Md.</u>
24. FUNERAL DIRECTOR <u>Warner G. Humphrey, Inc.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. REC'D BY REGISTRAR <u>John R. Thomas</u>		27. DATE <u>SEP 13 1967</u>	

12688

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE West Virginia b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c LENGTH OF STAY IN 1b 54 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Maryland		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Michael Shawn Mearns		4 DATE OF DEATH Month Day Year September 23 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 26 November 1962
9 AGE (In years last birthday) 4 yrs.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child (None)	
10b KIND OF BUSINESS OR INDUSTRY ---		11 BIRTHPLACE (County & State, or foreign country) Indiana	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME William E. Mearns	
14. MOTHER'S MAIDEN NAME Veda A. White		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herpes encephalo-myelitis DUE TO (b) Aspiration pneumonitis DUE TO (c) Acute lymphocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 month 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from July 31, 1967, to Sept. 23, 1967, that (he) (we) last saw the deceased alive on Sept. 23, 1967, and that death occurred at 9:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE Charles M. Haskell		22b DATE SIGNED Sept 23, 1967	
22c PHYSICIAN'S NAME (Type) Charles M. Haskell, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-27-67	23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d LOCATION (City or Town) (County) (State) Charleston W. Virginia
24 FUNERAL DIRECTOR Robert A Pumphrey		25a REC'D BY REGISTRAR SEP 29 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

CERTIFICATE OF DEATH

12699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>			d. STREET ADDRESS <u>1303 Morningside Drive</u>		
3 NAME OF DECEASED (Type or print) <u>Louise Gertrude Meehan</u> First Middle Last			4. DATE OF DEATH <u>Sept. 8</u> 19 <u>67</u> Month Day Year		
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Chauc</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 27, 1886</u>	9 AGE (In years, last birthday) <u>81</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State or foreign country) <u>Providence, Rhode Island U. S. A.</u>	
13 FATHER'S NAME <u>Farrell C. Fitzpatrick</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Tierney</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>yes</u>	17 INFORMANT <u>John Meehan</u> <u>1303 Morningside Drive Silver Spring, Maryland</u>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>1967</u> DUE TO (c) <u>last</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVA. BETWEEN ONSET AND DEATH <u>1967</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1967</u> to <u>Sept 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 8, 1967</u> , and that death occurred at <u>3:44 P.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Herbert C. Maganzini</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Herbert C. Maganzini</u>		22d. ADDRESS <u>520 E. 4th St. Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>	23b. DATE THEREOF <u>Sept. 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Pawtucket, Rhode Island</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		24b. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. RECD BY REGISTRAR <u>SEP 11 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	

MEDICAL CERTIFICATION

12691

CERTIFICATE OF DEATH

12700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>815 Brantford Avenue</u>	
3 NAME OF DECEASED (Type or print) <u>Harold</u> First <u>9</u> Middle <u>Meeth</u> Last		4 DATE OF DEATH <u>September 4</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1897</u>
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Post Office Clerk U.S. Post Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (County & State or foreign country) <u>U. S. A.</u>		12. C. TIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Henry Meeth</u>		14. MOTHER'S MAIDEN NAME <u>Martha Frincke</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218-26-1803</u>	
17. INFORMANT <u>Charlotte Bayln Meeth</u>		Address <u>815 Brantford Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10-12 mo</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>67</u> to <u>4 Sept</u> , 19 <u>67</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>3 Sept</u> , 19 <u>67</u> , and that death occurred at <u>1:34 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William D. And</u>		22b. DATE SIGNED <u>Sept. 4, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>		22d. ADDRESS <u>9006 Coleville Road Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 7, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Post Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co.</u>	
24. FUNERAL DIRECTOR <u>James E. Pumphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 8 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15
12892
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45
MEDICAL EXAMINER
CLEARED WITH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12701

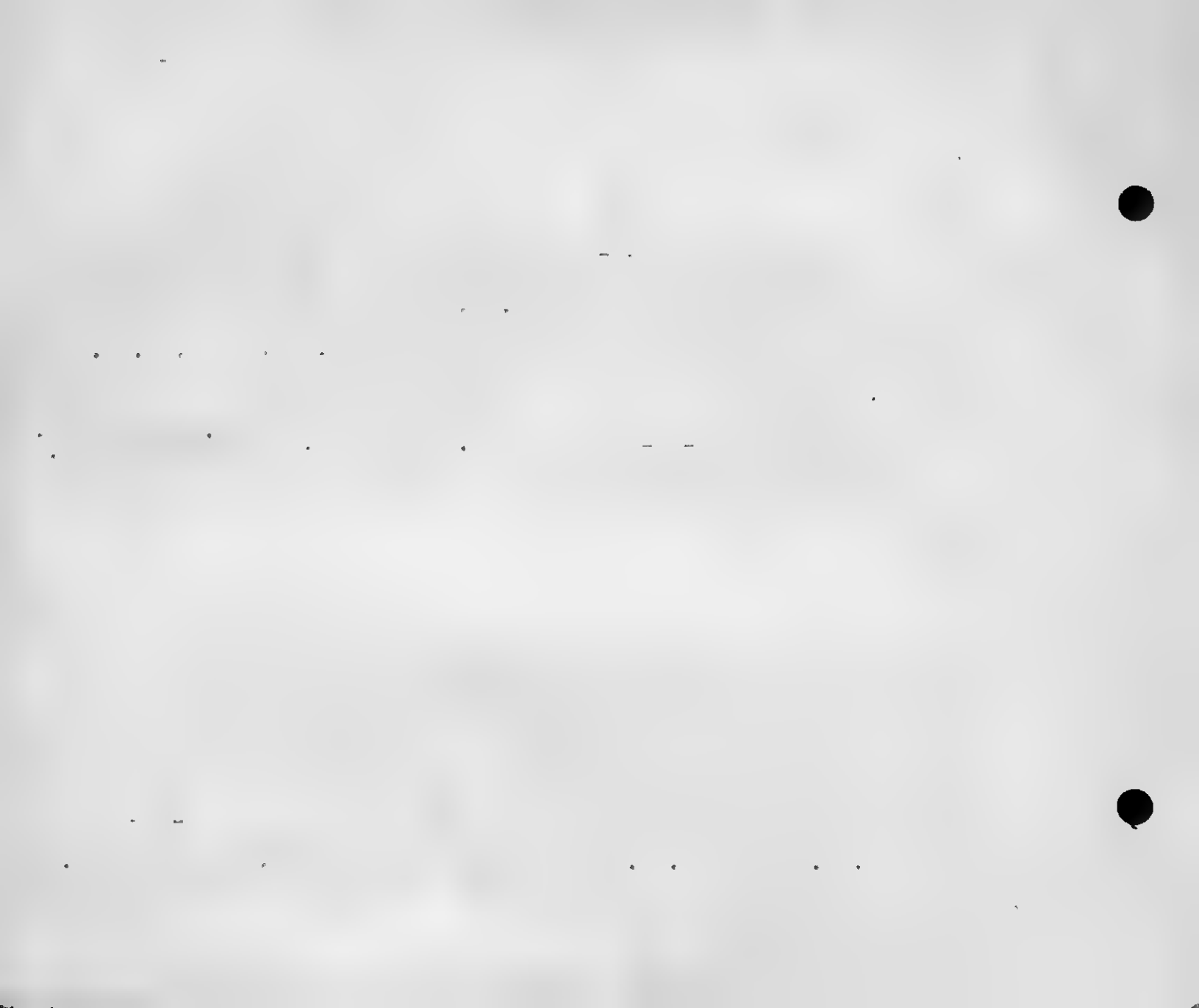
1. PLACE OF DEATH a. COUNTY <u>Takoma Park, MD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7214 Holly Ave Takoma Park, MD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RAILS NURSING HOME</u> <u>1420 Maple Ave</u>				d. STREET ADDRESS <u>7424 MAPLE AVE TAKOMA PARK, MD</u>			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>H</u> Last <u>MENDUM</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1967</u>		5. SEX <u>7</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DUNCANNON, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES</u>	
13. FATHER'S NAME <u>JOSEPH C. HAWLEY</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE REUTTER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SAMUEL W. MENDUM</u>		Address <u>7214 HOLLY AVE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u> 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>15 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PARKINSONISM, ADVANCED</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19, 1967</u> to <u>9/26, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/19, 1967</u> and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>LBSnow</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/26/67</u>			
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9-26-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>2. Wm. Lee + Sons</u>		23d. LOCATION (City, town or county) (State) <u>300 4th St N.E. Wash, DC</u>	
24. FUNERAL DIRECTOR <u>LEE FUNERAL HOME</u>		ADDRESS <u>300 4th St NE</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12693
CERTIFICATE OF DEATH
12702

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Potomac Valley Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 429 East Diamond Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Grace First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF DEATH September 15, 1967 9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of work ng. (If, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Fairfax County, Va. 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William A. Moxley 14. MOTHER'S MAIDEN NAME Susan Ellen Riley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 577-48-3427 17. INFORMANT Harry C. Merry, Sr. Address 429 E. Diamond Ave. Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) Fr. Left Hip PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-12-1967 to 9-15-1967 that (I) (we) last saw the deceased alive on 9-12-1967 and that death occurred at 9-15-1967 M, from the causes and on the date stated above.			
22a. SIGNATURE W. T. Joyce, M. D. 22c. PHYSICIAN'S NAME (Type) W. T. Joyce, M. D.		22b. DATE SIGNED 9-15-1967 22d. ADDRESS 4977 Battery Lane, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL, Subject 9/15/67 23b. DATE THEREOF 9/15/67		23c. NAME OF CEMETERY OR CREMATORY Andrew Chapel 23d. LOCATION (City, town or county) (State) Kienna, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE J. Berkeley Green, Herndon Va. ADDRESS Herndon Va.		25a. REC'D BY REGISTRAR SEP 26 1967 25b. REGISTRAR'S SIGNATURE James Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12594

12703

1. PLACE OF DEATH a. COUNTY Montgomery				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bethesda				c. LENGTH OF STAY IN 1b Great Cacapon				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 270				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE West Virginia				b. COUNTY West Virginia				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Cacapon				d. STREET ADDRESS Great Cacapon				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Irval				First Michael				Middle Michael				Last Michael				4. DATE OF DEATH Month September Day 6 Year 1967															
5. SEX Female				6. COLOR OR RACE Cauc.				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Dec. 14 1931				9. AGE (In years last birthday) 35 yrs.				10. IF UNDER 1 YEAR Months 7 Days 14 Hours 34 Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME George C. Youngblood				14. MOTHER'S MAIDEN NAME Core B. Whicker											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 10				17. INFORMANT Hospital Records				Address Hospital Records				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Injuries multiple severe DUE TO (b) Truck accident DUE TO (c) Truck accident CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH Seconds Seconds											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Passenger in cab of tractor trailer which ran into bridge abutment at high speed. Gasoline tank exploded and truck				20c. TIME OF INJURY Month, Day, Year Hour a.m. 5:30 9/6 1967				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 270				20f. (City or town) (County) burned (date) None Montgomery Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 9/6/67															
ACTUAL SIGNATURE John S. Rogers, M.D.				EXAMINER'S NAME (Type) John S. Rogers, M.D.				Address (Street, city, town or county) 1919 Seminary Rd. Silver Spring, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 10				23c. NAME OF CEMETERY OR CREMATORY St. Mike Cemetery				23d. LOCATION (City, town or county) (State) Morristown County, N.J.							
24. FUNERAL DIRECTOR John A. Ramsey, Bethesda, Md.				25a. REC'D BY REGISTRAR SEP 11 1967				25b. REGISTRAR'S SIGNATURE John A. Ramsey				25c. DATE SEP 11 1967				25d. REGISTRAR'S SIGNATURE John A. Ramsey															



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12695

12704

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hosp.</u>		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1210 Ruatan St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Sidney Louis Miller</u>		4 DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3-15-1900</u>
9 AGE (In years last birthday) yrs <u>67</u>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Abraham Miller</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO <u>UNKNOWN</u>		17 INFORMANT Address <u>20th St</u> <u>Wife) Mrs Anna Miller</u>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u>last.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Keap</u> EXAMINER'S NAME (Type) <u>BELDEN R. KEAP M.D.</u>		22. DATE SIGNED <u>9-26-1967</u>	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF <u>9-27-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Hebrew Burial Soc. Co. Inc.</u>		23d LOCATION (City or town) (County) (State) <u>Hebrew</u>	
24 FUNERAL DIRECTOR <u>Leibberg Funeral Home</u>		25a REC'D BY REGISTRAR <u>SEP 28 1967</u>	
ADDRESS <u>4217-9 Ave</u>		25b REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



21



CERTIFICATE OF DEATH

12696

12705

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>--</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN TB <u>30 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newport News</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				d. STREET ADDRESS <u>315 69th Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Grace Rose Mirmelstein</u>				4. DATE OF DEATH Month Day Year <u>September 20 19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 April 1913</u>		9. AGE (In years lost birthday) <u>54 yrs</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Banks</u>				14. MOTHER'S MAIDEN NAME <u>Mary Levinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure and Shock</u> DUE TO (b) <u>Bronchopneumonia</u> (c) <u>Sepsis (Staphylococcal) with Endocarditis and/ and liver</u> (d) <u>Mycosis Fungoides with involvement of lymph nodes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 August, 1967</u> , to <u>20 Sept., 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>20 Sept., 1967</u> , and that death occurred at <u>5:00 M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph D Croft Jr</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>20 Sept., 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph D. Croft, Jr., MD</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-remov</u>		23b. DATE THEREOF <u>9.22.67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rosenbaum Mem. Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Hampton, Virginia</u>	
24. FUNERAL DIRECTOR <u>W.G. Turbyfill Jr</u>				25a. REC'D BY REGISTRAR <u>SEP 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Harvey J. J...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

12706

1. PLACE OF DEATH a COUNTY Montgomery b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c LENGTH OF STAY IN Tb		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE D.C. b COUNTY Washington	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edna Jefferson Moore		4. DATE OF DEATH Month Day Year 9 - 23 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1894	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) Stoney Creek, Virginia	
13. FATHER'S NAME Juddi Jefferson			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-26-2454		17. INFORMANT Spurgeon Johnson, Wash D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 1 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/17 , 19 67 , to 9/23 , 19 67 that (I) (we) last saw the deceased alive on 9/23 , 19 67 , and that death occurred at 4 p.m. from causes and on the date stated above.					
22a. SIGNATURE Myron L. Lenker		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/23/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL/CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 27-1967	23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Prince Geo. County Md.		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR Lalney's Funeral Home, Wash. D.C.		ADDRESS 3831 Ra. av.		25a. RECEIVED BY REGISTRAR SEP 27 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12698

CERTIFICATE OF DEATH

12707

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1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 32 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		d. STREET ADDRESS 1115 Bellview Road	
3. NAME OF DECEASED (Type or print) First Hazel Middle (NMN) Last Moore		4. DATE OF DEATH Month September Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 April 1924
9. AGE (In years last birthday) 43 yrs		10. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
11. BIRTHPLACE (Country & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Terrell		14. MOTHER'S MAIDEN NAME Malinda Everett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -- (If yes give war or dates of service) --		16. SOCIAL SECURITY NO 227-46-9772	
17. INFORMANT The Medical Records		18. ADDRESS The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and Cardiac Arrest DUE TO desmoid tumors Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Laparotomy, excision of abdominal wall for / DUE TO (c) Gardner's Syndrome			INTERVAL BETWEEN ONSET AND DEATH 90 minutes 48 hours 40 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 13 August , 19 67 , to 14 Sept. , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 14 Sept. , 19 67 , and that death occurred at 9:20 M. from causes and on the date stated above.			
22a. SIGNATURE Frederick R. Eilber, M.D.		22b. DATE SIGNED Sept. 14, 1967	
22c. PHYSICIAN'S NAME (Type) Frederick R. Eilber, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL CEMETERY OR CREMATORY (Specify) Shiloh Baptist Church Va	23b. DATE THEREOF 9-18-67	23c. NAME OF CEMETERY OR CREMATORY Shiloh Baptist Church Va	23d. LOCATION (City or town) (County) (State) McLean, Va
24. FUNERAL DIRECTOR James E. ...		25a. REC'D BY REGISTRAR SEP 19 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12699

12708

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>2201 Virginia Ave. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Melba V. Morrison</u>				4. DATE OF DEATH Month <u>9</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>12/29/21</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Personnel Spec.-FOREIGN-SERVICE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED MORRISON</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA CLARK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>286-143024</u>		17. INFORMANT <u>MRS. H.M. DIEHL-JEFFERSON</u> Address <u>ST. RED HILL, PA</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Adeno carcinoma of Pancreas</u> DUE TO (c) <u>no.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>67</u> , to <u>9/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/9</u> , 19 <u>67</u> , and that death occurred at <u>10:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. G. Lennard Gold</u>				22b. DATE SIGNED <u>9/9/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Lennard Gold</u>	
22d. ADDRESS <u>8641 Colesville Road, S.S. Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>9-13-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Lawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

12709

12700

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6815 Fairfax Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A</u> Last <u>MURRAY</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE (In years last birthday) yrs. <u>83</u>
11. BIRTHPLACE (County & State, or foreign country) <u>York, Pa</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James Murray</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Kauffelt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>068-09-3327</u>	
17. INFORMANT <u>Wife</u>		Address <u>Theresa S. Murray</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>PARKINSONISM</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 DAYS</u> <u>3 YRS</u> <u>5 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>67</u> , to <u>9/12</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/11</u> 19 <u>67</u> , and that death occurred at <u>1A</u> M, from causes and on the date stated above.		20f. (City or town) (County) (State)
22a. SIGNATURE <u>[Signature]</u>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>9/12/67</u>
22c. PHYSICIAN'S NAME (Type) <u>ORL E. DOWNS</u>	22d. ADDRESS <u>6218 WISCOUR BETHESDA MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>
25a. REC'D BY REGISTRAR DATE <u>SEP 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

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